CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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FREEDOM OF CHOICE

Virginia Medicaid recipients are free to choose a Medicaid enrolled medical equipment and supply provider when medical equipment and supplies are a covered service. Provision of "free" supplies or items to Medicaid recipients as an enticement for their business may violate federal law. If a provider is found to be utilizing this practice, DMAS may impose a civil money penalty sanction against the DME provider.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing and/or coordinating the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. The PCP's name and telephone number is listed on the recipient's MEDALLION identification card. Refer to the "Managed Care Section" section of this manual for further details on the program.

COVERED SERVICES

DME and supplies are a covered service available to the entire Medicaid population. In addition, the Department of Medical Assistance Services (DMAS) may cover DME services when any of the following are met:

- The recipient is under age 21 and the item or supply could be covered under the Virginia *State Plan for Medical Assistance* (the *State Plan*) through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); or
- The recipient is enrolled in the Technology Assisted Waiver Program; or
- The recipient is enrolled in the AIDS Waiver Program.

All medically necessary medical equipment and supplies under the *State Plan* may be covered only if they are necessary to carry out a treatment prescribed by a physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the services from the MEDALLION PCP. The PCP referral is valid as long as the Certificate of Medical Necessity (CMN) is effective, provided there is no change in the eligibility of the recipient or PCP. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective

by DMAS, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165, D 1a)

DME providers shall adhere to all applicable DMAS policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of reimbursement for durable medical equipment and supplies that are regulated by such licensing agency or agencies. (12 VAC 30-50-165)

MEDICAL NECESSITY

Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS. Medically necessary DME and supplies shall be:

- Ordered by the physician on the CMN/DMAS-352;
- If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or the PCP;
- A reasonable and medically necessary part of the recipient's treatment plan;
- Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;
- Not furnished for the safety or restraint of the recipient, or solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
- Furnished at a safe, effective, and cost-effective level; and
- Suitable for use in the recipient's home environment.

(12 VAC 30-50-165)

NON-COVERED DME AND SUPPLIES

For individuals under age 21, coverage must be explored under Early and Periodic Screening, Diagnosis and Treatment (EPSDT). For details, see the "DME Covered under Early and Periodic Screening, Diagnosis and Treatment" section on page 58 of this manual.

For all other recipients, non-covered supplies and equipment include, but are not limited to, all of the following:

- Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;
- Durable medical equipment and supplies for any hospital or nursing facility

resident, except ventilators and the associated supplies that are approved by DMAS and provided to nursing facility residents;

- Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, geri-chairs, and bathroom scales);
- Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed, a wheelchair tray used as a desk surface, and mobility items used, in addition to the primary assistive mobility aid), for the caregiver's or the recipient's convenience (e.g., an electric wheelchair plus a manual chair); underpads (such as chux) in addition to incontinence briefs, unless there is a specific medical need for using both; and cleansing wipes;
- Prostheses, except for artificial arms, legs, and their supportive devices which must be preauthorized by DMAS (effective July 1, 1989).
- Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or for improving the functioning of a malformed body member (for example, over-the-counter drugs, dentifrices, toilet articles, shampoos which do not require a physician's prescription, dental adhesives, electric toothbrushes, cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; non-compression type support stockings; and non-legend drugs);
- Home or vehicle modifications;
- Orthotics (including braces, splints, and supports);
- Items not suitable for or not used primarily in the home environment (e.g., car seats except when medically necessary under EPSDT, equipment to be used while at school, etc.); and
- Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.).

(12 VAC 30-50-165)

CERTIFICATE OF MEDICAL NECESSITY (CMN)/DMAS-352

All DME and supplies must be ordered by a physician on the CMN/DMAS-352 (revised 8/95) and must be medically necessary to treat a health care condition. The CMN (DMAS-352) may be completed by the physician, DME provider, or other health care professionals, but the physician must sign and date the completed CMN. (See "EXHIBITS" at the end of this chapter for a sample of this form.) If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. This referral may be obtained in writing or orally and must be documented in the recipient's record. The CMN and any supporting verifiable documentation must be completed (signed and dated by the physician) within 60 days from the time the ordered DME and supplies are initially furnished to the recipient by the DME provider (effective July 1, 1998). DMAS will not reimburse the DME provider for

services provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the first day the DME supplies are furnished to the recipient**.** (12 VAC 30-50-165)

A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient's functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or on an attachment to the CMN. The additional documentation to justify the DME or supplies must coincide with the date of service for the item(s) ordered and the name and title must identify the medical discipline. The CMN must also be completed for equipment repairs. (12 VAC 30-50-165)

DME must be furnished exactly as ordered by the attending physician on the CMN. The physician must specifically order each component of the DME on the CMN. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary for the ordered DME or supplies, as indicated by the recipient's condition, the DME provider must obtain a new CMN. The attending physician must sign and date the new CMNs within 60 days from the time the ordered supplies are furnished by the DME provider. Supporting documentation may be attached to the CMN, but the attending physician's entire order must be on the CMN. (12 VAC 30-50-165)

NOTE: If technical information changes on the CMN, a new CMN is not required because it does not affect the physician's order or delivery of services. Examples of technical information include changes in a recipient address, phone number, or provider enrollment number. The next CMN renewal must include this updated technical information. Faxed copies of the CMN are acceptable.

Length of Certification on the CMN (DMAS-352)

The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum validity time for Medicaid recipients older than 21 years is twelve months. DMAS has the authority to determine length of time different from these two lengths of time that a CMN may be valid based on medical documentation submitted on the CMN. The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies ends. (12 VAC 30-50-165)

Retention of Medical Records

For recipients currently receiving a DME service, copies of all CMNs, all supporting verifiable medical documentation, and all associated billing documentation must be kept on file at the location serving the recipient. For recipients no longer receiving a DME service, completed CMNs, all supporting verifiable medical documentation, and all associated billing documentation must be retained by the provider for at least five years. (12 VAC 30-50-165)

Retroactive Eligibility

DMAS policy regarding retroactive eligibility is to make an exception to the 60-day physician signature requirement. All remaining criteria (e.g., fully completed CMN, documentation requirements, and specific coverage criteria) must be satisfied in accordance with the *State Plan* and DMAS policy guidelines.

CMN Exceptions

A CMN is not necessary for AIDS waiver recipients for nutritional supplements.

A CMN is not required for recipients for whom Medicare is the primary insurance carrier and Medicaid is the secondary carrier. In those instances, if Medicare approves the DME item(s), the provider must bill on the DMAS-30 invoice. Medicaid will pay the appropriate deductible and/or co-insurance, and no CMN is needed for this Medicare crossover coverage. If the item(s) is not covered by Medicare and is covered by Medicaid, the fully completed CMN is required in order for Medicaid to pay as the primary carrier.

For private primary insurance where Medicaid is secondary payer, the CMN is required, even if it only applies to a copayment. Medicare is the only exception where a CMN and preauthorization would not be required (e.g.: crossover claim).

PREAUTHORIZATION PROCESS

When extended utilization or unusual amounts of equipment and/or supplies are required, the provider must request preauthorization. The "Medicaid DME and Supplies Listing"/Appendix B which is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS), describes equipment and supplies and identifies those which require preauthorization. Preauthorization is required for items identified with a "Y" in the authorization column of the DME Listing/Appendix B, and for any item exceeding the established limits identified in the "limit" column of the DME Listing/Appendix B. If the item does not require preauthorization or does not exceed the established limits, the provider may provide and bill for these items up to the established limit without preauthorization. If preauthorization is required, preauthorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The purpose of preauthorization is to validate that the service or item being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service. Payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Preauthorizations are specific to a recipient, a provider, a service code, an established quantity, and for specific dates of service. (12 VAC 30-50-165)

Telephonic Preauthorization

DME providers have the option of submitting preauthorization requests for most services

either telephonically or on paper. Preauthorization requests for unpriced DME HCPCS codes for amounts over $3,500, specialized wheelchairs, and ventilator purchases must be submitted on paper. There may be circumstances other than those previously listed where the provider will be required to submit written documentation in order to obtain preauthorization.

Preauthorization of DME and supplies must be obtained through the WVMI, the DMAS contractor effective February 17, 1997. All initial telephonic requests, as well as any information submitted in response to pend letters, must be directed to WVMI.

To make a telephonic request, providers call WVMI and provide the information requested to the WVMI analyst. The analyst will require information similar to the information described below to be included on the DMAS-351 form. Additionally, the provider must verify that the required documentation and justification exists in accordance with Federal and State regulations, and DMAS published criteria, policy, and procedures. Fully completed CMNs with appropriate medical justification will be verified upon DMAS post payment review audit and may be requested for preauthorization if WVMI determines it to be necessary.

While the provider is on the telephone, the WVMI analyst may provide the provider with a tracking number for services that have been approved, pended, or denied. Written verification of the analyst's decision will also be sent to the provider. Make telephonic preauthorization requests directly to WVMI at the following telephone numbers:

(804) 648-3159 Richmond Area

(800) 299-9864 All Other Areas

DMAS-351 Completion

In cases previously listed where paper preauthorization is required, or if the provider chooses to continue the paper preauthorization request process, the DMAS-351 form (5/94 revision) must be utilized. (See the "EXHIBITS" section at the end of the chapter for a sample of the form.). Instructions for completing the DMAS-351 are found on the reverse side of each request form. The completed DMAS-351, with the appropriate documentation, must be submitted to:

DMAS Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

The following are points of clarification for use when requesting preauthorization via the DMAS-351 form. Additionally, telephone preauthorization requests follow the DMAS-351 guidelines described below, without the paper requirement. While completion of the DMAS-351 form is not required for telephonic preauthorization, having the DMAS-351 required information readily available will assist in expediting the telephonic preauthorization process.

Section I: Transaction Type

- Original: Use for all new requests. All sections of the DMAS-351 (Section I through Section VII) must be filled out completely and accurately.

- Change: Use when requesting a change to a previously approved request; the provider may change the service code, quantity of units, dollar amount requested, or dates of service. When submitting a "change" request, the provider must write the original tracking number in Section I of the DMAS-351 and mark "change." The provider may not submit a "change" request for any item that has been denied or is pended.

  The provider must complete Sections I through Section III when submitting a "change" request. Sections V and VI only need to be filled out if there is a change within the section. Section VII must be completed for each line that requires a change to any box. Identify the service code to be changed and insert the changes to be made in the appropriate columns in Section VII. (If the change requires additional quantities or a longer period of time, appropriate justification must be attached.)

  If an incorrect service code (HCPCS, CPT, or NDC) has been requested, identify in the provider comment section the approved code to be changed, and complete Section VII for each new service code requested. To void a service code (i.e., completely void a line item), identify the service code to be voided in the provider comment. Action will only be taken on this service code. The action status on other service codes under the same preauthorization number will not be changed.

  If a "change" request for a miscellaneous code is submitted, identify the original HCPCS modifier for each miscellaneous code that requires a change. The provider must sign and date the change request.

- Delete: Use when voiding all of the items under one preauthorization number. For example, use "delete" when authorization under the wrong recipient or provider number has been received. Do not submit a "delete" request if only a portion of an approved preauthorization number is to be deleted. A request that has been denied cannot be "deleted."

  Sections I through Section III must be fully completed when submitting a "delete" request. The provider must sign and date the delete request.

Section II: Provider Information

Submit the appropriate seven-digit Medicaid provider number. Requests submitted by a provider for a date of service on which the provider was not enrolled with DMAS will be rejected.

Identify a contact person and telephone number of someone who will be able to answer or coordinate the answers to any questions regarding the preauthorization request.

Authorizations are specific to a provider number and may not be shared with any other provider.

Changes in Provider Ownership

- If a provider changes ownership and a new provider number is issued, all approvals issued under the old provider number for dates of service to be provided under the new provider number must be transferred to the new provider number.

- To request this change, the provider must submit a "change" request under the old provider number and identify the appropriate end date for each service code that had been authorized (but not billed for), and then submit an "original" request under the new provider number with the appropriate quantities and new begin date.

- In the comment section of each new "original" request, the provider must state "Change of ownership; item previously approved under (insert old provider number) provider number."

- In these situations, DMAS will transfer the "original" authorizations as approved; any changes required must be submitted as a "change" request after the transfer of the approval to the new provider number.

Section III: Recipient Information

The recipient's 12-digit Medicaid number must be complete and valid for the dates of service being requested. (Numbers ending in "00-*" ARE NOT VALID RECIPIENT NUMBERS.) Virginia Medicaid recipients are eligible on a monthly basis; for example, a recipient eligible in January may become ineligible in February. The provider is responsible for verifying the Medicaid eligibility of the recipient every time a service is delivered. The provider may do so by either checking the recipient's Medicaid card or calling the Recipient Eligibility Verification System (REVS). REVS is available 24-hours-per-day, seven-days-a-week. (Information regarding REVS can be found in Chapter I.)

Other insurance, such as Medicare or other insurance, must also be identified in this Section of the DMAS-351.

Section IV: Referral Source Information (optional)

Complete Section IV to request notification of action on the preauthorization to be sent to the referring provider. Referral sources may include home health agencies, clinics, physicians, etc.; however, only identify one referral source. The referral source must be identified by the referral provider's seven-digit Medicaid provider number.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP.

The provider must contact the referral source to obtain the Medicaid provider number; this information will not be given by the DMAS HELPLINE.

Section V: Program Category

Select the appropriate program from which the recipient is eligible to receive requested services. Select one category per preauthorization request. Multiple selections will result in the request being rejected.

- Select the DME category of service if you are requesting DME services, and
- Select the appropriate program category if the recipient is eligible for the DME service being requested under the EPSDT program.

Section VI: Service Category

Select the appropriate service category that describes the service code being requested; only select one category per preauthorization request. Multiple selections will result in the request being rejected. This selection is based on the type of service being requested and does not imply the type of provider supplying the service.

Section VII: Request Information

Identify the specific HCPCS being requested. The computerized system will not recognize specific CPT or NDC codes for DME services. Narrative descriptions will not be accepted.

- Units Requested: Only identify the number of units necessary in excess of the established allowable (if 4 units are allowed and 6 units are needed, the units requested should be 2). Place numbers only in the "Units Requested" block. The amount requested should reflect the amount required for the entire from and through dates of the request. Units requested as 2/2 months or 100/box X months or 7 days cannot be keyed and will be rejected.

- Actual Cost: This column must be completed when requesting a miscellaneous code or a code requiring individual cost consideration. Submit actual cost less any incentives or reductions received from the manufacturer. Attach validation of cost (an invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.). Requests for items that require individual cost consideration without attached validation of cost or that contain conflicting cost data will be pended. This cost is per unit of the item being requested.

- Total Dollar Requested: Identify the total dollars requested for miscellaneous codes by multiplying the provider's usual and customary charge by the total number of units requested (e.g., the usual and customary charge is $2.00 and 6 units are needed, the total dollar requested would be $12.00).

- Dates of Service: Identify the dates of services for which the corresponding service codes are requested. Dates must be written in numerical form (e.g., July 1, 2002, would be written 07/01/02). A from date and a through date must be entered on the DMAS-351, otherwise, it will be rejected by the system.

The signature of the provider and date of the request must appear in section VII of the DMAS-351. Stamped or typed signatures are not accepted in this section. By signing in the appropriate space, the provider certifies that the DMAS-351 has been reviewed for accuracy and is responsible for the contents (costs) submitted.

Submission of the DMAS-351

Send completed DMAS-351s marked "original," "change," or "delete" (Section I, Transaction Type) to the fiscal agent using the same green-bordered envelope used when submitting the HCFA-1500 claim form. Attach securely to the DMAS-351 all accompanying information. Do not leave it loose in the envelope. Unattached material will be returned to the provider if identifiable.

When submitting a request for a single recipient requiring more than six service codes, complete additional DMAS-351s and staple together the entire package for that recipient. If a preauthorization request is submitted that contains multiple pages of DMAS-351s for a recipient, fully complete all sections of each DMAS-351 for that recipient. If multiple DMAS-351s for multiple recipients are submitted, do not staple multiple recipient packages together.

Submission of Additional Information

Additional information may be provided via telephone unless otherwise indicated. If WVMI has received a request and determined that additional information is necessary to complete the review process, the provider will receive information by telephone, and/or will be mailed a computer-generated letter, identifying the specific information that is needed. WVMI has the option of requesting written information at their discretion. If submitting additional information via telephone, contact WVMI directly.

If submitting additional information in writing, return the computer-generated letter with the additional information to the address listed on the computer-generated letter.

Attach the computer-generated letter on top of the additional information being sent for review. It is the responsibility of the provider to coordinate and submit the additional information that has been requested. Additional information must be submitted within 30 days of the date on the letter. If information has not been received within the allowed time period, the request will automatically be rejected. If the request for authorization is rejected, but the authorization is still needed, a new "original" request must be submitted, and all supporting documentation must be attached.

If the computer-generated letter is not available, attach a separate note stating "Additional Information" and clearly identify the original preauthorization number. Packages or documents that are received and are not clearly identified will be discarded if they cannot be matched with the original request. When submitting written information in response to a pended request, send the package to:

WVMI
Bank of America Center
1111 East Main Street, Suite 402
Richmond, VA 23219

Handling of Rejected DMAS-351 Requests

Reject action reason codes (beginning with a "400") may be applied at several points during the review process either by the fiscal agent or by WVMI. The preauthorization request may be rejected for various technical reasons (e.g., incomplete areas). Rejections are not clinical denials and, therefore, cannot be appealed by the recipient or provider.

DMAS-351 forms that do not contain the requesting provider's seven-digit provider number or do not contain the provider number and the twelve-digit recipient identification number will be rejected before entry into the system. If the requesting provider has written its address on the form, the fiscal agent will return the entire package to the requesting provider. This will be the only circumstance in which the DMAS-351 and attachments will be returned to the provider. There will be no record on the automated preauthorization file of these requests ever having been submitted.

Providers will be notified of other reject actions at the point in which the reject action code is applied. This information will be stored on the automated preauthorization file, and providers may inquire for preauthorization status by contacting the DMAS Provider HELPLINE (1-800-552-8627). Remember that the HELPLINE is for provider use only. Do not give the Provider HELPLINE number to recipients.

Action reasons are applied to each service code being requested. If more than one service code is requested, the entire DMAS-351 package may contain multiple action codes (some codes/line items may be denied, others rejected, others pended for additional information, and others approved). Reject reasons applied automatically by the system at the fiscal agent's location are done before the DMAS-351 package is forwarded to WVMI for review. Service codes that pass all the system-generated reject and denial edits are forwarded to WVMI for staff review.

WVMI will not review those service codes that have been denied or rejected by automated system edits.

Once the provider receives a reject reason for a requested service code, the provider must submit a new DMAS-351 package and indicate that it is an "original request" in order to have the service preauthorized. The new package must contain all necessary supporting documentation. The provider may not bill a recipient for covered services where the preauthorization package is rejected with a reject reason code.

Miscellaneous HCPCS Codes

Use the appropriate HCPCS codes when requesting preauthorization. Miscellaneous codes may only be used when the item requested differs significantly in narrative description from the established HCPCS code. Miscellaneous codes will not be recognized for the sole

purpose of cost variances**.** In order for WVMI to determine the appropriate reimbursement for miscellaneous items, all of the following information must be provided:

- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s); and
- Any discount received must be indicated.

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of the cost for specially designed items, are all acceptable documentation. The documentation must include the manufacturer's cost, any discount provided to the provider, and the provider's ancillary cost of providing the DME and/or supplies to the recipient.

Preauthorizations containing multiple E1399 lines must be identified on the HCFA-1500 by entering the two-digit DMAS-351 line number (e.g., 01, 02, 03, etc.) in the modifier field (Locator 24D) on the HCFA-1500.

Payments for DME and supplies will be based on DMAS' estimate of the usual charge for the item by all providers. A mark-up of 30 percent of the actual cost (less any discounts available to the DME provider), as determined by WVMI, may be used in some instances where there is no established usual charge pattern. The reimbursement will be based on the provider description of the item(s) or supplies. Complete itemization is required in the Provider Comment Section of the DMAS-351 or as an attachment. Adequate and complete descriptions, quantities, and the unit price are essential for the evaluation of the charge. Wherever possible, use the appropriate HCPCS codes.

Preauthorization Reconsideration and Appeals Process

If services are denied by the WVMI analyst and the DME provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied, the provider may either request telephonic or written reconsideration from the WVMI Outpatient Review Services Supervisor within 30 days of the date of the denial. The WVMI Outpatient Review Services Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. If a written request is denied, the provider must submit a letter to the WVMI Preauthorization Supervisor, requesting reconsideration within 30 days of the notice of denial, to:

WVMI
Outpatient Review Services Supervisor
Bank of America Center
1111 East Main Street, Suite 402
Richmond, Virginia 23219

After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of

the written notification of denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DOCUMENTATION REQUIREMENTS FOR ALL DME

Medical documentation must provide DMAS with a clear understanding of the recipient's needs. The following applies to the medical justification necessary for all DME services regardless of whether preauthorization (PA) is required. The documentation is necessary to identify:

- The medical need for the requested DME;
- The diagnosis related to the reason for the DME request;
- The recipient's functional limitation and its relationship to the requested DME;
- How the DME service will treat the recipient's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- The frequency of use;
- The estimated length of use of the equipment;
- Any conjunctive treatment related to the use of the DME or supplies;
- How the needs were previously met identifying changes that have occurred which necessitate the DME;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the DME service is required in the recipient's home environment; and
- The recipient or caregiver's ability, willingness, and motivation to use the DME.

There must be a physician-generated diagnosis and treatment order which demonstrates the need for the item(s) and supporting documentation, especially for expendables which are beyond the established guidelines for use. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or the PCP. This referral may be obtained in writing or orally and must be documented in the recipient's record. All covered services must be reasonable and medically necessary; recipient assessments may be required to determine that a particular treatment is reasonable and necessary. ((12 VAC 30-50-165*)*

If the amount requested exceeds the limit specified in the DME Listing/Appendix B, the provider must request preauthorization for those items exceeding the limit. The provider may supply the recipient with the amount of items up to the limit prior to obtaining preauthorization from DMAS for the overages. If the physician orders items or quantities that are not consistent with the standard in medical or nursing practice, supporting documentation must be provided to justify the order.

Specialized DME, such as hospital beds, specialized wheelchairs, augmentative communication devices, adaptive equipment, and rehabilitative therapy equipment, must be accompanied by a recipient assessment performed by a qualified therapist which details the recipient's functional abilities and disabilities, therapy goals, rehabilitation potential, suitability for use in the home environment, and how the equipment will be used in the recipient's home. (See the section of this chapter concerning specific documentation requirements). If in-home rehabilitative therapy equipment is ordered, the in-home therapy plan must be included.

For items that may be either used for the convenience of the caregiver or recipient or to treat or manage a medical condition (e.g., hospital beds), supporting documentation of the medical need and use of the equipment must be included. Medicaid does not cover items for restraint of the recipient or for the convenience or safety of the recipient, the family, the attending practitioner, other practitioners, or the supplier. (12 VAC 30-50-165)

Note: Supplies used during the course of the home visit by personnel of the home health agency are not subject to separate reimbursement by DMAS. These kinds of expendable medical supplies (e.g., gauze, cotton, and adhesive bandages, Foley catheters and Foley insertion trays) are included in the visit fee paid to the home health agency. The only supplies relative to the home health visit for which the DME provider may receive separate reimbursement are those supplies which remain in the home beyond the time of the visit to allow the recipient or caregiver to continue the treatment.

SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to the Medical Necessity guidelines described on page 2 of this chapter, and the previously described documentation requirements for all DME, specific medical justification and/or documentation requirements are in place for the following DME:

Hospital Beds

Describe all of the following: How the bed will be used to treat a medical condition; how needs have and are currently being met; the functional abilities/disabilities; other alternatives tried; and why a non-hospital bed would not meet the recipient's medical needs.

Patient Lifts

Describe all of the following: the recipient's weight; identify the caregiver and his or her ability to use the lift; describe the recipient's functional limitations; explain how needs were previously met and what has changed in the recipient's condition to require the lift; and describe the home accessibility for the lift.

Wheelchairs and Components

Specialized wheelchairs must be accompanied by a comprehensive "hands on" evaluation completed by a health care professional with experience in fitting wheelchairs and making

recommendations based on the individual recipient's need (specifically, physician, physical therapist, occupational therapist, or rehabilitation engineer in coordination with the physical therapist or occupational therapist). The physical therapy and/or occupational therapy wheelchair evaluation is a covered service that may be billed to DMAS. DMAS requires the assessment to be performed by a physical therapist or occupational therapist, especially for wheelchairs with specialized seating and positioning components and features, or for wheelchairs operated via specialty electronics. Specialized or customized wheelchairs may also include HCPCS codes in the DME list which do not require preauthorization, but that may require a physical therapist's and/or occupational therapist's evaluation. For all wheelchairs and components, the provider must identify all of the following:

- Document the diagnosis or condition requiring the wheelchair, AND how the requested wheelchair treats that diagnosis/condition.
- Document the diagnosis or condition requiring each requested component AND how the requested component treats that diagnosis/condition.
- Describe the distance (in feet**)** that the recipient can functionally ambulate with assistive devices if any.
- Describe upper and lower extremity strength/weakness in relation to the type of wheelchair/components requested.
- Identify problems with tone or spasticity in relation to the specific components/type of wheelchair requested.
- Describe the recipient's head and trunk control in relation to the specific components/type of wheelchair requested.
- Describe the recipient's ability/inability for self-propulsion in relation to the specific wheelchair/components requested.
- Identify how the recipient's needs have been met/unmet previously and what has changed in the recipient's condition to require a mobility device.
- If the recipient currently owns a wheelchair, describe the type of wheelchair, condition of the wheelchair (describe damage/cost to repair), and any special features included on the wheelchair.
- Identify cost-effective alternatives explored/tried and describe how these alternatives do not presently meet the recipient's medical needs within the home environment.
- Describe the home accessibility for the mobility device and how the requested mobility device is required within the recipient's home environment. (Documentation must indicate that the recipient is able to use the wheelchair within the home environment.)
- If requesting the wheelchair under a miscellaneous code, describe any special features that the requested wheelchair has that are not available on a standard, light weight, or high strength, light weight wheelchair for which Medicaid has an established HCPCS code; include size, construction, and weight restrictions, etc., as applicable.
- Documentation for powered mobility devices must describe how the recipient's needs cannot be met within the home environment in a manual wheelchair, i.e., a standard, light weight, or ultra light weight wheelchair.
- For special seats, backs, and cushions, document postural concerns, asymmetries, levels of sensation, history, or actual risk of skin breakdown; the length of time the recipient will be in the wheelchair per day; mobility

impairments; and how all of these conditions relate to the need for the seating system/cushion requested.

Note: All items related to wheelchairs, including correct quantities, hardware, upgraded foam, labor, any item that is an upcharge, etc., must be ordered on the CMN, and justified either on the CMN or in attached, supporting, verifiable documentation, regardless of whether or not the item requires preauthorization. All supporting documentation must be recipient-specific and must be signed and dated by the physician.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The following wheelchair related items are not covered: mobility devices used in addition to the primary means of mobility; mobility devices not required for use primarily within the home environment, i.e., strollers, scooters, or wheelchairs for community use; wheelchairs for restraint purposes; and home or vehicle modifications, i.e., wheelchair ramps. (12 VAC 30-50-165)

Wound Care Supplies

Describe all of the following: The total number of wounds; the location, stage, size, depth, drainage, and color of each wound; who is doing the wound care (recipient, caregiver, home health nurse); the frequency of the wound care; and the complete physician's order for the wound care.

Additional documentation requirements for specific items may be found in the "Medicaid DME and Supplies Listing" in Appendix B and in the following pages describing specific coverage criteria.

SPECIFIC COVERAGE CRITERIA

Augmentative Communication Devices

DMAS will consider reimbursement for electronic or manual augmentative communication devices when the device is deemed medically necessary. Medical necessity will be determined by DMAS after reviewing all submitted documentation. Communication devices to improve educational and/or vocational abilities are not covered services by Medicaid. (12 VAC 30-50-165)

One of the following criteria must be met before an augmentative communication device can be considered for approval:

- The recipient cannot functionally communicate basic needs verbally or through gestures due to medical conditions, and expressive language is not expected to be restored. Basic needs include eating, drinking, toileting, and indicating discomfort or pain; or

- The recipient cannot verbally or through gestures participate in medical care, i.e., indicate decisions regarding medical care or indicate medical needs; or

- The recipient cannot verbally or through gestures functionally communicate informed consent on medical decisions.

In accordance with the Virginia State Plan for Medical Assistance, all of the following must be met before an augmentative communication device can be considered for approval. The communication device must be:

- Ordered by the physician on the CMN/DMAS-352, and if the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP;

- A reasonable and medically necessary part of the recipient's treatment plan;

- Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;

- Not furnished solely for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier;

- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

- Furnished at a safe, effective, and cost effective level, primarily for use in the recipient's home environment.

Requests for augmentative communication devices must be submitted on a DMAS-351 Preauthorization Request with an attached DMAS-352 CMN. Requests must be accompanied by a systematic and comprehensive speech/language evaluation, completed by a speech-language pathologist licensed by the Department of Health Professions and signed and dated by the recipient's physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The speech-language pathologist may not be a provider of augmentative communication systems nor have a financial relationship with a provider/manufacturer.

A 30 to 60 day trial rental period must be considered for all electronic devices to assure that the chosen device is the one most appropriate to meet the recipient's medical needs. (Note: For those recipients whose needs can be clearly defined by the comprehensive speech-language pathologist's evaluation, a trial rental period is not necessary.) At the end of the trial rental period, if purchase of the device is recommended, documentation by the speech-language pathologist of the recipient's ability to use the communication device must be provided. The speech-language pathology documentation must show that the recipient's ability to use the device is improving and that the recipient is motivated to continue to use the device. If the communication device(s) supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in

the DME Listing in addition to the initial two-month rental period for these items.

The DMAS-352, speech/language evaluation, and/or other verifiable supporting documentation must include all the following:

- The complete physician's prescription for the augmentative communication device, including an itemization of the components (i.e., special switches, special mounting devices, etc.) required by the recipient;

- Documentation describing the recipient's medical condition/diagnosis, including a description of the recipient's disease, general prognosis, and prognosis for intelligible speech. (Is the condition permanent, temporary, or changing? Will this medical condition result in an increased or decreased need for a device in the future?);

- A description of how the recipient communicates medical needs now and how communication needs are currently met and un-met;

- Is the recipient cognitively/physically able and motivated to use an augmentative communication device? Documentation must include an assessment of the recipient's gross and fine motor skills, e.g., hand use skill, including finger dexterity;

- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit his or her ability to use a device, or that would require the use of a particular augmentative communication device;

- A description of the plan to provide ongoing speech-language pathology training and support in the use of the communication device in the recipient's home and community; A list of other devices that have been tried by the recipient (describe the success/failure); a description of how the requested device better meets the recipient's medical needs than more cost-effective devices available;

- A description of the extent to which the recipient and/or family/caregivers are able to program and utilize the device; and

- Specific information about the device including: the manufacturer's name, catalog number, product description, a picture (if available), and documentation of the provider's cost, less any discounts available.

Collaborative Funding

Based on House Joint Resolution 697 (1995), an effort should be made to promote the removal of identified barriers and seek to broaden and improve access to assistive technology devices and services to persons with disabilities, within the guidelines established in the Virginia Administrative Code. When the requested device is needed partially for medical purposes and partly for educational, vocational, or social needs, the communication assessment team must pursue the possibility of a collaboration of funding sources. In addition to DMAS, these funding sources might include the local school division, the Department of Rehabilitative Services, private foundations, the recipient's

family/friends, and charities or other non-profit groups.

If the recipient/family requests to act as a funding source for portions of the device found to be "not medically necessary" and therefore, not covered by Medicaid, the DME provider must maintain documentation that the recipient/family was charged, per their request, for Medicaid non-covered services. However, the recipient/family may not be charged for services that are medically necessary and covered by Medicaid. The DME provider must accept Medicaid's payment as payment in full for services that are medically necessary and covered by Medicaid.

Once another funding source is identified, DMAS must be contacted to negotiate a collaborative funding formula. When pursuing collaborative funding of a device, the speech/language pathologist must include previously described documentation and must delineate which components are felt to be medically necessary and which are educational, vocational, etc. If a device is determined to be medically necessary, DMAS will approve the level of funding for a device that meets the recipient's medical needs. If a more complex device is required to meet the educational/social/vocational needs as well as the medical needs of the recipient, the remainder of the funding must be provided by an alternative funding source.

Each request for collaborative funding will be reviewed on an individual basis. The assessment team must notify DMAS as soon as possible of a situation that might require collaborative funding so that acquisition of the device by the recipient will not be delayed. Payments toward funding of the device must be made directly to the provider and not to the recipient. Payments to the recipient may be viewed as "income" and could potentially affect the recipient's eligibility for Medicaid.

Although collaborate funding is primarily utilized for communication devices, there may be other DME for which collaborate funding is appropriate.

Assistive-Technology Equipment

Assistive-technology equipment includes, but is not limited to, recipient lifts, bath chairs, wall-mounted insulin delivery devices, and automatic feeder systems. All assistive-technology equipment must be medically necessary and essential for the treatment of illness or injury. Assistive technology equipment does not include home modifications (e.g., devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways); furniture and appliances not defined as medical equipment such as bathroom scales and hand-held shower devices; items that are not for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body part; and equipment when the primary function is vocationally or educationally related (e.g., computers and environmental control devices). (12 VAC 30-50-165)

The following conditions must be met for DMAS to approve reimbursement of assistive-technology equipment. These conditions are applicable whether the equipment is for initial use or replacement. Approval may occur under one of the following categories:

1. Recipient-Based Outcomes (one of the following must be met):

    - An identified, realistic goal exists that makes necessary the use of the assistive-technology equipment for the treatment of the medical condition; or

    - Anticipated stabilization of the medical condition or progress toward goal achievement is clearly related to the use of the equipment.

2. Supportive Activities to Accomplish Outcomes (all of the following must be met):

    - Goal(s) must be a part of an active, rehabilitative, therapeutic plan of care in place at the initiation of the use of the equipment. The goal(s) must be realistic in that it is consistent with the recipient's cognitive, environmental, and physical status;

    - The recipient or caregiver demonstrates the ability cognitively, motivationally, and physically to effectively utilize the equipment toward goal achievement. Someone is available to regularly assist the recipient as necessary in the use of the equipment to facilitate progress toward the goal achievement;

    - Within the plan of care, documentation exists that other equipment and/or health care alternatives have been considered and rejected as not appropriate for the treatment of the medical condition;

    - The recipient does not have a deficient level of "energy" or other systemic condition (e.g., CHF, COPD) that adversely impacts the ability to participate in the use of the equipment; and

    - The equipment must reduce the need for other reimbursed health care such as personal care, private duty nursing, rehabilitation services, and/or home health services.

Blood Glucose Monitors

DMAS will reimburse for blood glucose monitors and associated supplies for recipients eligible for the DME program or EPSDT when all of the following criteria are met:

- The recipient has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings, or the recipient has clinically demonstrated unstable glucose readings and must report frequent findings to a physician for adjustment of hypoglycemic medications; and

- There must be written verification that the recipient and/or caregiver have participated in diabetic training (diet, medication, monitoring, etc.) and that the recipient and/or caregiver have demonstrated the ability to appropriately use the

prescribed blood glucose monitor.

For Pregnant Women

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for whom the physician determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome (effective for dates of service on and after July 1, 1993).

The Certificate of Medical Necessity (CMN-352) is not required. However, the physician's orders for the blood glucose monitor and test strips and supplies must be documented on the Maternity Risk Screen form. This form is initiated/completed by the local heath department clinic or the attending physician.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or the PCP.

Disposables to Carry Out Infection Control Procedures

The following recommendations regarding disposable items are based on current guidelines from the Centers for Disease Control. Disposable items, including, but not limited to, gloves, gowns, and masks, will be covered only when necessary to carry out universal precautions if the caregiver (e.g., family member) is in contact with the recipient's blood and/or other body fluids containing visible blood, or for the specific and medically documented symptoms of impaction.

For individuals enrolled in the Medicaid-funded Technology Assisted Waiver Program, non-sterile gloves may be used when performing tasks related to tracheostomy care, such as suctioning. The reason for this exception in the use of non-sterile gloves is to reduce the risk of coming in contact with blood and reducing the risk of infection. The Technology Assisted Waiver recipient is more susceptible to serious infection and possible repeated hospitalizations due to their fragile respiratory needs.

Disposable items will not be covered for use by the caregiver (e.g., family or provider agency) in carrying out routine infection control procedures (e.g., gloves to clean an incontinent recipient, handle soiled linen, clean or empty a bedside commode, empty a urinary drainage bag, or to bathe a recipient). (12 VAC 30-50-165*)*

DMAS will not provide reimbursement for items necessary to carry out either routine or universal precautions when the care is being supplied by a provider agency. The provider will be responsible for the provision of equipment and supplies necessary to minimize the risk of infection including the transmission of the HIV virus and other blood-borne pathogens.

Disposables Related to Incontinent Supplies

DMAS will not provide reimbursement for the routine use of diapers for children under three years of age. Preauthorizations for diapers for children must be associated with a medical condition; preauthorization will not be made solely on the fact that toilet training has not been accomplished.

The quantity of incontinence briefs per case may vary per manufacturer. DMAS has established minimum quantity requirements based upon an analysis of the industry standards. In order to bill for a case under the assigned HCPCS codes listed in Appendix B, the quantity per case provided must fall within or exceed the range listed in the comments section of the DME Listing. For sanitation reasons, cases may not be opened and repackaged by the provider. The case must be delivered as packaged by the manufacturer.

The CMN must include a description of the recipient's incontinent condition and the frequency of use to justify the quantity ordered by the physician. Additional medical justification is required for quantities requested beyond the established allowable limits.

Many Medicaid recipients are utilizing disposable incontinence briefs and underpads on a routine monthly basis. In most cases, the underpads are needed to protect the bed and are not for a separate medical need. Unless the recipient has a specific medical need, in addition to incontinence, for using the underpad along with the incontinence briefs, DMAS will not provide reimbursement for underpads when used in conjunction with incontinent briefs since a washable pad serves the same purpose as the disposable underpad. (12 VAC 30-50-165)

Adult Pull-Up Style Briefs

Coverage is available for adult pull-up style briefs for incontinent individuals when this type of brief is medically necessary as part of an active bowel and/or bladder training program. A bowel and/or bladder program is a program, recommended by a medical professional (physician or home health nurse in consultation with the physician), that is carried out on a consistent basis. For example, if a recipient is incontinent but has the potential to become continent, then the opportunity to train his bowel and/or bladder to work properly is justified. A urologist or a gastroenterologist may be treating the recipient as well. The bowel and/or bladder program may involve assisting the recipient to and from the bathroom every two hours to train the bowel and/or bladder to function on a regular schedule. It may also involve other toileting activities including assisting the recipient with removal of clothing, hence the need for the pull-up style brief. Otherwise, this pull-up style brief would serve no purpose for a recipient who is incontinent and who has no potential for improvement. If the recipient requires adult pull-up style briefs secondary to the recipient's participation in a bowel and/or bladder training program, documentation of the bowel and/or bladder training program for the recipient is required and must be described on the CMN/DMAS-352. (The DME Listing allowance for the existing pediatric brief HCPCS codes is sufficient to cover pediatric pull-up style briefs.)

Enteral Nutrition

Coverage of enteral nutrition, which does not include a legend drug, is limited to instances in which the supplement is the sole source of nutrition. Exceptions include those recipients authorized through the Technology-Assisted and AIDS Waivers, or through EPSDT, where the supplement must be the primary source of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does not include the provision of routine infant formulae. (12 VAC 30-50-165)

"Sole source" means that the recipient is unable to tolerate (swallow or absorb) any other form of oral nutrition. "Primary source" means that nutritional supplements are medically indicated for the treatment of the recipient's condition if the recipient is unable to tolerate nutrients. The recipient may either be unable to take any oral nutrition or the oral intake that can be tolerated is inadequate to sustain life. The focus must be the maintenance of weight and strength commensurate with the recipient's medical condition.

All of the following shall apply to the provision of enteral nutrition:

- Enteral nutrition shall be reimbursed only to enrolled DME providers. If a pharmacy is currently providing enteral nutrition, but is not enrolled as a DME provider, the pharmacy must become an enrolled DME provider in order to be reimbursed for services;

- Enteral nutrition shall be based on categories of nutritional components (refer to the DME Listing/Appendix B);

- The physician's order (the CMN) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided. If a physician orders a specific brand of supplement, the DME provider must supply the brand prescribed. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective provided there is no change in the eligibility of the recipient or the PCP. The physician's order must include the daily caloric order and the route of administration for the supplement. Where applicable, existing Medicare codes and reimbursement rates will be utilized. An additional category has been added to include certain pediatric supplements that are not covered by Medicare;

- The physician's order (the CMN) is valid for a maximum of six months regardless of the recipient's age. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, registered nurse, or a registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six (6) months. The DMAS-115 Nutritional Status Evaluation Form (Revised 10/99) is required every six (6) months and contains the elements listed below.

The DMAS-115 form is required for all individuals receiving nutritional supplements, and the DMAS-115 must be signed and dated by the assessor within 60 days of the DMAS-115 begin service date. If the DMAS-115 is not signed and dated by the assessor within 60 days of the DMAS-115 begin service date, the DMAS-115 will not become valid until the date of the assessor's signature. (See the "EXHIBITS" section at the end of this chapter for a sample of the form). Note: Home health visits for the sole purpose of performing a nutritional assessment for recipients whose conditions are stable and chronic in nature will not be covered under the home health program;

- The Nutritional Status Evaluation Form/DMAS-115 must include all of the following elements:

  1. Height (or length for pediatric recipients);
  2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the recipient's weight loss over time;
  3. Formula tolerance (e.g., is the recipient experiencing diarrhea, vomiting, constipation?). This element is only required if the recipient is already receiving a supplement;
  4. Tube or stoma site assessment, as applicable;
  5. Indication of whether the supplement is the primary or sole source of nutrition;
  6. Route of administration;
  7. Section F must include the daily caloric order and the number of calories per package, can, etc.
  8. Extent to which the quantity of the formula is available through WIC; and
  9. Title, signature, and date of the person completing the assessment.

Preauthorization of enteral nutrition is not required. The DME provider must assure that there is a valid physician's order (CMN) and DMAS-115 Nutritional Status Evaluation Form completed every six months in accordance with DMAS policy and on file for any Medicaid recipient for whom enteral nutrition is provided. The DME provider is further responsible for assuring that enteral nutrition is provided in accordance with DMAS reimbursement criteria (e.g., sole source or primary source.) Upon postpayment review, DMAS will deny or retract reimbursement for any supplements that are not provided and billed in accordance with the criteria described in the manual.

When HCPCS codes B4154 (Category IV) and B4155 (Category V) are used, the provider must attach a copy of the fully completed DMAS-115 Nutritional Status Evaluation Form and a copy of the supplier's manufacturer's invoice to the claim in order for the claim to be paid. The manufacturer's invoice must document the cost per package, can, etc., and the calories per package, can, etc.

The HCFA-1500, in Locator 24A, must indicate the appropriate from and through dates to indicate the length of time for which the supply was delivered. The HCFA-1500, in Locator 24G, must list the units. Units must be calculated as follows: daily caloric intake/divided by 100, multiplied by the number of days supplied. DMAS will pend claims

for HCPCS B4154 and B4155 for manual review.

For nutritional supplements without an existing rate established by DMAS, providers may receive a 5% markup above cost for reimbursement under HCPCS codes B4154 and B4155.

For recipients under the age of five, the DME provider must have documentation from the Women, Infant, and Children Supplemental Food Program (WIC) regarding the extent of coverage of nutritional supplements through WIC. Medicaid will cover amounts not covered by WIC. Medicaid may cover any remaining amounts not covered by the WIC Program up to the current allowable reimbursement limits for nutritional supplements outlined in the DME Appendix B listing which appears at the end of this manual.

Recipients in the AIDS/HIV Waiver must continue to have their enteral nutrition authorized as part of the AIDS Waiver authorization process.

DME providers are not required to obtain the DMAS-113B or DMAS-114 for the provision of nutritional supplements for AIDS Waiver recipients for dates of service on or after September 1, 1999. The DMAS-115 Nutritional Status Evaluation Form is the only form required by the DME provider for AIDS Waiver recipients to receive nutritional supplements from September 1, 1999, until March 1, 2000.

Effective with begin dates of service on or after March 1, 2000, in addition to the DMAS-115 form, the DMAS-352 (CMN) is required for all nutritional supplements and supplies regardless of whether or not the recipient is enrolled in a waiver program. Prior to March 1, 2000, a DMAS-352 (CMN) is not required for AIDS Waiver recipients.

For recipients eligible for enteral nutrition, the DME provider must obtain and maintain all of the following information:

- The CMN;
- Nutritional Status Evaluation form (DMAS-115); and
- A statement of eligibility for WIC services for children under the age of five.

See the "Medicaid DME and Supplies Listing" in Appendix B for a current listing of the supplements covered by DMAS. If the supplement that has been ordered by the physician is not found on the list, contact the DMAS Provider HELPLINE. The Provider HELPLINE will assist the DME provider in obtaining a classification for all supplements not listed.

Home Infusion Therapy

Home Infusion Therapy is the intravenous (IV) administration of fluids, drugs, chemical agents, or nutritional substances to recipients in the home setting. DMAS will reimburse for the services, supplies, and drugs only when they are determined to be:

- Medically necessary to treat a recipient's medical condition;

- In accordance with accepted medical practice; and
- Not for the convenience of the recipient or the recipient's caregiver.

The recipient must:

- Reside in either a private home or a domiciliary care facility, such as an adult care residence. Recipients in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access; and
- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the recipient is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid Medicaid provider number to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;
- Pharmacies; and
- DME providers.

A provider must be enrolled as a Medicaid provider, to include all of the following:

- Meet any state licensing and certification requirements;
- Render infusion therapy covered services;
- Use Medicaid-established billing guidelines; and
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

Medicaid has assigned a service day rate code and reimbursement rate for each of the covered therapies:

- Hydration therapy;
- Pain management;
- Chemotherapy;
- Drug therapy; and
- Total parenteral nutrition (TPN).

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the recipient is enrolled in one of the waivered services outlined under "Special Considerations." Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, the separate HCPCS code Z7778 has been developed to allow for the rental of a second infusion pump and the purchase of extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Implementation Form (DMAS-354). (See the "Exhibits" section at the end of this chapter for a sample of this form.) Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. The service day rate payment will be in two service categories: durable medical equipment (DME) and pharmacy.

Items in the DME service day rate include all supplies required to administer I.V. therapy, including, but not limited to, the:

- I.V. pump/pole rental/control devices;
- Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; and
- I.V. start kits and central venous catheter dressing kits.

Items in the pharmacy service day rate include the:

- Diluent for the therapeutic agent;

- Mixing and compounding;
- Flush kits and solutions (heparin and saline); and
- Cassettes and bags/mini-bags.

Payment for the active ingredient is billed separately using the most current version of the Daily Pharmacy Drug Claims Ledger form (DMAS-173), Point-of-Service (POS) on-line billing, or other approved electronic billing method.

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

Preauthorization

The designated HCPCS codes for DME services do not require initial preauthorization, but will have a limit of three months. If the service is needed beyond the three-month-limit, it must be preauthorized.

Special Considerations

Providers of I.V. therapy services to those recipients enrolled in special or waivered Medicaid programs must abide by all the guidelines of the program in which the recipient is enrolled.

Nursing Visits

Nursing visits for I.V. therapy are reimbursed under home health services. To receive reimbursement for the I.V. therapy nursing services, the provider must be a Medicaid home health provider with a valid home health provider number. If a nurse from a company that is a non-participating Medicaid home health provider acts as a "back up" for the nurse at the home health agency, the two companies must make arrangements between themselves for reimbursement. The home health visit reimbursement for all nursing services, includes but is not limited to, travel time, recipient education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the DME service day rate allowance to whichever provider furnishes the supplies.

Drugs

Drugs providing the therapy's active ingredient are reimbursed according to Medicaid's payment methodology. Payments for the active ingredient shall be the lowest of:

- The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs and on the Virginia Voluntary Formulary (VVF), except if "Brand Necessary" is noted on the prescription by the prescriber;

- The Virginia Maximum Allowable Cost (VMAC) established by DMAS for multiple source drugs listed on the VVF;

- The estimated acquisition cost established by DMAS (currently the Average Wholesale Price minus 10.25% [AWP-10.25%]); or

- The provider's usual and customary charge to the public, as identified by the claim.

Multiple Therapies

Multiple therapies of the same therapy are included in one service day rate of reimbursement. For example, if a recipient receives two antibiotics under drug therapy on the same day, the provider may only bill one service day rate for the DME and pharmacy services. In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. The individual antibiotics may be billed separately as active ingredients on the most current version of the Daily Pharmacy Drug Claim Ledger form (DMAS-173), Point-of-Service (POS) on-line billing, or other approved electronic billing method.

Multiple therapies of different therapies under DME will be reimbursed at 100% for the most expensive therapy and 50% for the second and each additional therapy. For example, if a recipient receives chemotherapy, hydration, and pain management on the same day, the DME provider may bill $44.00 for pain management, $18.50 for chemotherapy, and $15.00 for hydration, based on current rates.

Multiple therapies of different therapies under pharmacy will be reimbursed at 100% for each therapy and may be billed on the HCFA-1500 (12-90) claim form. Bill for the active ingredient on the most current version of the Daily Pharmacy Drug Claim Ledger form (DMAS-173), Point-of-Service (POS) on-line billing, or other approved electronic billing method.

Certificate of Medical Necessity (CMN)

The CMN must be completed for I.V. therapy DME services. The provider may fill out the CMN, but the physician must date and sign the CMN within 60 days of the begin date of service. If the recipient is enrolled in MEDALLION, the ordering physician must be the

MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

DMAS will not reimburse the DME provider for any DME and supplies provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the first date of service. Under the item/service and HCPCS code on the CMN, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the physician within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must also be attached to each CMN and I.V. Therapy Implementation form upon completion of the therapy. The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form (DMAS-354) may be completed by the provider, but must be signed and dated by the physician. DO NOT ATTACH EITHER THE I.V. THERAPY IMPLEMENTATION FORM (DMAS-354) OR THE CMN TO CLAIM REQUESTS. DME providers must adhere to all requirements set forth in the Virginia *State Plan for Medical Assistance* and the DME provider manual and DME Medicaid Memos as they relate to the completion of the CMN and supporting documentation.

Pharmacy

The service day rate for covered I.V. services is explained below. The rate for TPN therapy includes the usual components of this therapy. However, the service day rate does not include the fluids for hydration therapy or the active ingredient in chemotherapy, pain management, or drug therapies. Bill for these components separately as pharmacy claims. In this manner, the active ingredient is identifiable in the Drug Utilization Review (DUR) program and the Centers for Medicare and Medicaid Services (CMS) rebate program operated by the agency.

Hydration Therapy

Definition: Hydration therapy is the intravenous administration of fluids, electrolytes, and/or other additives.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Electrolytes and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

Use HCPCS code Z7779. Bill on the HCFA-1500 (12-90) claim form.

The hydration solution is billed on the most current version of the Daily Pharmacy Drug Claim Ledger (DMAS-173), Point-of-Service (POS) on-line billing, or approved electronic billing method.

The DME service day rate includes, but is not limited to:

- The I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extension sets, gloves, alcohol wipes, needles, dressing/start kits, etc.

Services beyond three months require preauthorization.

Use HCPCS code Z7771. Bill on the HCFA-1500 (12-90) claim form.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Pain Management

Definition: Pain management is the intravenous administration of narcotics and other drugs to relieve pain.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs**:** Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

Use HCPCS code Z7781. Bill on the HCFA-1500 (12-90) billing form.

The DME service day rate includes, but is not limited to: I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extension sets, remote reservoirs, needles, alcohol wipes, gloves, dressing/start kits, etc.

Preauthorization is required for services beyond three months.

Use HCPCS code Z7773. Bill on the HCFA-1500 (12-90) claim form.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Chemotherapy

Definition: Chemotherapy is the administration of chemical agents designed to have a specific effect upon disease causing cells or organisms.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs**:** Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

Use HCPCS code Z7780. Bill on the HCFA-1500 (12-90) claim form.

The DME service day rate includes, but is not limited to:

- The I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extensions sets, needles, alcohol wipes, gloves, dressing/start kits, spill kits, etc.

Services beyond three months require preauthorization.

Use HCPCS code Z7772. Bill on the HCFA-1500 (12-90) claim form.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple chemotherapies are included in the one service day rate.
- Hydration solutions may be billed separately.

Drug Therapy

Definition: Drug therapy is the intravenous administration of antibiotics or other drugs.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

Use HCPCS code Z7782. Bill on the HCFA-1500 (12-90) claim form.

The DME service day rate includes, but is not limited to, the:

- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, remote reservoirs, alcohol wipes, gloves, dressing/start kits, etc.

Services beyond three months require preauthorization.

Use HCPCS code Z7774. Bill on the HCFA-1500 (12-90) claim form.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple drug therapies are included in the one service day rate.

TPN

Definition: TPN is the administration of nutritional substance by intravenous infusion to nourish recipients who are malnourished or may develop malnutrition and who are not candidates for enteral support.

The pharmacy service day rate includes, but is not limited to:

- Covered drugs: Diluent, electrolytes, nutritional additives, lipids, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

Use HCPCS code Z7783. Bill on the HCFA-1500 (12-90) claim form.

The DME service day rate includes, but is not limited to:

- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, alcohol wipes, gloves, dressing/start kits, etc.

Services beyond three months require preauthorization.

Use HCPCS code Z7775. Bill on the HCFA-1500 (12-90) claim form.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- The pharmacy service allowance includes solutions, additives (such as KCL and MVI), and lipids. Insulin is an example of a medication that may be billed separately with TPN therapy.

Post-Payment Review

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid recipients. For DME services, I.V. therapy providers must maintain records

that contain the fully completed CMN, signed and dated by the physician; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the physician; and the order to discontinue the therapy (the official end date), signed and dated by the physician. These forms shall be furnished to DMAS staff upon request. The absence of documentation to support I.V. therapy services may result in the retraction of moneys.

Codes for Use with Purchased I.V. Pumps

For those cases where a recipient owns an I.V. pump for the long-term administration of I.V. therapy, two DME codes have been created to reimburse for service day rate services.

Use HCPCS code Z7776 (Drug Therapy DME) for those recipients who own their own IV pump and require IV drug therapy. The reimbursement does not include the pump rental, but does include an allowance for battery reimbursement.

Use HCPCS code Z7777 (TPN Therapy DME) for those recipients who own their own I.V. pump and require TPN therapy. The reimbursement does not include the pump rental, but does include an allowance for the battery reimbursement.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. HCPCS code Z7778 (Incompatible Drug Therapy DME) may be billed in addition to the service day rate when the documentation supports drug incompatibility.

Equipment Repairs

The cost to repair rental equipment is considered the DME provider's responsibility. Therefore, rental repair charges, caused by normal wear and tear, abuse, or neglect, may neither be billed to DMAS nor to the recipient. All HCPCS codes listed in Appendix B must have a CMN physician order, including equipment repairs.

Charges for repair(s) to medically necessary, recipient owned equipment may be billed to DMAS using the proper DMAS HCPCS code. The provider should document in the recipient record if the equipment is recipient owned. If the repair cost is less than the rate paid under HCPCS Z4350, and the repair is done by the DME provider, the DME provider must bill DMAS under the miscellaneous parts/repair code (Z4350) and the labor code Y1350 as applicable. If the cost of the repair parts exceeds the rate paid under HCPCS Z4350, or if the repair requires that the item be shipped to the manufacturer, the provider must use the miscellaneous (E1399) HCPCS code, where the 30% mark-up concept is applicable (preauthorization is required).

The provider must accept Medicaid payment as payment in full and may not bill the recipient for any portion of the repair, including shipping and handling charges. Costs incurred for shipping and handling, except when otherwise noted, are considered to be a part of the DME provider's overhead/business expenses. If the repair is covered under warranty, the provider serving the recipient's DME needs is responsible for the cost of shipping and handling. If a provider accepts a Medicaid recipient as a client, the provider must provide all of the DME services that are provided to the general population.

Rehabilitative Equipment

Rehabilitation equipment includes, but is not limited to, tilt tables, prone standers, parallel bars, and balance balls. This equipment is designed to bring a recipient into an upright position or to stimulate vestibular function, or to stimulate balance.

The following conditions must be met for DMAS to approve reimbursement of these types of rehabilitation equipment. These conditions are applicable whether the equipment is for initial use or replacement. (12 VAC 30-50-165)

1. Recipient-Based Outcomes (at least one of the following must be met):

    - An identified, realistic goal of functional ambulation exists and/or the recipient has achieved progressive mobility goals at the time the equipment is requested (i.e., the recipient is able to come from supine to sit, able to maintain dynamic sitting balance, and to right balance; the recipient is actively pursuing ambulation goals; and there is a reasonable expectation the goal(s) will be achieved, such as with the use of tilt tables, prone standers, etc.); or

    - An identified goal of a level of functional independence in activities of daily living exists, the achievement of which depends upon the recipient's maintaining an upright position in order to maximize the use of the upper extremities and/or to increase visual/perceptual integration, such as with the use of tilt tables, prone standers, etc.; or

    - An identified goal of a level of functional independence in ambulation and/or activities of daily living exists, the achievement of which is dependent upon the stimulation of vestibular function, balance, and/or neurodevelopmental progression, such as with the use of balance balls, etc.

2. Supportive Activities to Accomplish Outcomes (all of the following must be met):

    - Goal(s) must be part of an active, rehabilitative, therapeutic plan of care in place at the initiation of use of the equipment. The goal(s) must be realistic in that it is consistent with the recipient's cognitive, environmental, and physical status;

- The recipient and/or caregiver demonstrates the ability cognitively, motivationally, and physically to effectively utilize the equipment toward goal achievement. Someone is available to regularly assist the recipient as necessary in the use of the equipment in order that progress toward goal achievement can occur;

- The recipient does not have a deficient level of "energy" or other systemic condition (e.g., CHF, COPD) that adversely impacts the ability to participate in the use of the equipment; and

- The equipment must reduce the need for other reimbursed health care such as personal care, private duty nursing, rehabilitation services, and/or home health services.

Respiratory Equipment and Services

Apnea Monitors

Apnea monitor usage for recipients with one of the following diagnoses or identified high-risk conditions may be approved for payment if the diagnosis/condition is supported with a completed CMN and includes appropriate supporting and verifiable documentation:

- Apparent life-threatening episode(s), i.e., gastro esophageal reflux, severe; apnea; seizures; cardiac arrhythmias;
- Apnea of prematurity;
- Bronchopulmonary dysplasia/chronic lung disease of infancy with oxygen dependency;
- Respiratory control disorder such as: congenital hypoventilation, obstructive sleep apnea, central apnea, obstructive airway disease;
- Infant or child with tracheostomy;
- Infant of drug-dependent mother, symptomatic for apnea;
- Sibling of SIDS (payment will be made for six months from birth or up to one month beyond age of sibling at time of death); and
- Congenital anomalies, at risk of airway obstruction.

If the recipient does not have any of the above diagnoses, the request will be reviewed in accordance with the following criteria:

Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not covered. The recipient may use either the recording or non-recording monitor. At least one of the following must be evidence for an initial and/or ongoing continued use, with appropriate, supporting, individualized documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause, or an inadequate response to treatment; or

- Documented apnea associated with bradycardia, cyanosis, or pallor; or
- History of apnea described by parent or caretaker and documented in the medical records; or
- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Initial approval for payment will be for a period up to four months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to DMAS for review and preauthorization.

Reimbursement for apnea monitors will be discontinued when a clinical evaluation (including neurological, developmental, and physical examinations) shows that the initial problems or conditions requiring the monitor have been resolved or stabilized. Reimbursement will be discontinued when one of the following scenarios occurs:

- The recipient has been free of events requiring stimulation or resuscitation for 2-4 months; or
- The recipient has experienced significant stressors such as respiratory illness or immunizations without apnea; or
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnagrams, and Multi-Channel Sleep Studies

Definitions:

A pneumogram is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the recipient is monitored on a recording apnea monitor.

A multi-channel sleep study contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2.

A polysomnagram includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2, EEG x2, EOG x2, and EMG, attended by a technologist.

Reimbursement for these studies will be considered by DMAS based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied must be determined by the attending or ordering physician.

Documentation on the CMN must specify the number of signals, what signals are to be done and whether or not interpretation is to be done. Documentation must also include the download findings and a wave form analysis. A summary report of the study must be maintained at the provider's location.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. Should a recipient with a recording monitor need a pneumogram, the DME provider must submit a request for preauthorization.

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies:

For the initial 120 days which do not require preauthorization, there must be a Certificate of Medical Necessity (CMN) stating the recipient's diagnosis that indicates the need for a monitor or a description of the recipient's condition. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The following documentation is required for the continued use of an apnea monitor over 120 days (both 1 and 2):

1. A CMN and documentation outlining the condition of the recipient related to apnea in the previous 120 days of monitoring, including all of the following:

    a) The dates and the number of occurrences of observed apnea;

    b) An interpretation of any related diagnostic tests;

        For example: an upper GI series for GE reflux; pneumograms or downloads for recording apnea monitors, that are interpreted and indicate the child had clinically significant apnea during the first 120 days and/or the condition is resolving;

    c) Download reports with clinical interpretation from recording monitors. The physician is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to document the clinical status;

    d) Adequate and verifiable documentation of the oxygen flow rate for those recipients who continue on oxygen; and

    e) Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome (SIDS) if the child was placed on the monitor for this reason.

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor findings or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during

the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, need to reach significant age for a sibling of SIDS), and a physician's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the recipient's physician to interpret the data. It is the responsibility of the provider to obtain the interpretation from the physician and submit the interpretation to DMAS.

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals, what signals are to be done, and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

Criteria for Rental versus Purchase of an Apnea Monitor

DMAS does not require preauthorization for the initial 120 days of use. If the physician determines that the recipient will need the apnea monitor beyond 120 days, but less than eight (8) months, the DME provider must obtain preauthorization for continued rental from DMAS. To obtain preauthorization, the DME provider must submit supporting documentation for the additional time requested. If the physician determines that the recipient will need the apnea monitor eight (8) months or longer, the DME provider must request purchase of the apnea monitor. This request must include supporting documentation at the initiation of service or at the time of determination of long-term usage. At the time of purchase, the DME provider is required to provide a new monitor with a full manufacturer's warranty. (12 VAC 30-50-165))

Non-Compliant Behavior

The provider shall document the non-compliant use of the apnea monitor in the recipient's file. Non-compliant use of the apnea monitor by the recipient or the recipient's caregiver is a refusal to provide care necessary for the child's health and creates a substantial risk of death for the child. The provider shall report non-compliant behavior to the attending physician or health care professional. There shall be compliance with 12 VAC 30-50-165. DMAS shall continue to reimburse for the monitor while reasonable efforts to ensure compliant behavior are taken.

Service Maintenance Agreements for Purchased Apnea Monitors

HCPCS code Z5908 covers the service and maintenance of purchased apnea monitors and requires preauthorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six [6] months). Downloading can be done during a trouble-shooting visit. The provider can utilize these 18 visits for any combination of trouble-shooting or download visits. (See the "Medicaid DME and Supplies Listing" in Appendix B for the allowable limits and reimbursement information.)

Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling is covered in HCPCS code Z5907, and preauthorization is required. A copy of the manufacturer's invoice for

servicing must be attached to the claims invoice. The claim invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs (Y1350 and Z4350).

All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff who are available to make timely necessary home visits related to the use of the apnea monitor. The provider must assure that the staff is qualified to render the necessary services;

- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are:

    - 12 disposable electrodes or 2 reusable electrodes
    - 2 leadwires, and 2 rib belts.

Additional supplies that are medically justified must be preauthorized;

- The costs for trouble-shooting and download visits will be included in the service maintenance agreement fee (18 visits per six [6] months). Downloading can be done during a trouble-shooting visit. These 18 visits can be used by the provider for any combination of trouble-shooting or download visits;

- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services. The provider may bill DMAS for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer;

- The cost of parts which constitute a repair must be billed separately, as a repair, using the established HCPCS codes for repairs; and

- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code. The provider must attach a copy of the CMN and manufacturer's invoice to the claim in order for the claim to be paid. DMAS will pend claims for this HCPCS code for manual review.

CO_2 Monitors

CO_2 monitors are typically used for ventilator dependent recipients in the acute care setting, often in conjunction with a pulse oximeter. Their use is most frequently required in conjunction with a sleep study, typically in conjunction with efforts to wean recipients from

ventilator use. Continuous use of the CO_2 monitor in the home has not been demonstrated to be medically necessary, and its use by non-skilled caregivers to change ventilator settings is not considered advisable. Therefore, coverage is available only in certain limited circumstances for the cost of conducting a capnograph study, when ordered by the physician.

CO_2 studies will be approved for the purpose of weaning from a ventilator or for recipients who have a history of CO_2 retention which requires periodic monitoring. These studies will not be approved for obstructive sleep apnea. All requests must be preauthorized. The DME provider must obtain a CMN, completed by the physician who treats the recipient's pulmonary condition. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The CMN must address the reason for the study, the length of time the study will require, and the frequency requested within the six-month preauthorization period. Two nights will be the maximum length of the study which will be reimbursed. The CO_2 monitor reading must be submitted to the physician for assessment, and the physician must report back to the DME provider regarding any changes to be made based upon the physician's evaluation of the reading taken. Requests for further studies after the first request must include documentation of the progress toward weaning or evidence of continued CO_2 retention. If the physician does not indicate that progress toward weaning is shown or can be expected, the request may be denied.

The amount of reimbursement for the CO_2 study will depend on whether DMAS is reimbursing for the professional component necessary to assure an accurate reading is obtained. For a recipient receiving in-home nursing care (e.g., Technology-Assisted Waiver recipients), the health care coordinator will discuss with the nursing agency and DME provider whether the private duty nurse is knowledgeable and comfortable with the use of the equipment for the study. If the nurse is able to assure an adequate reading, the DME provider will be reimbursed for the cost of the delivery of the equipment, a one-day rental of the equipment, and a scoring fee for the CO_2 study. If the nurse is not able to assure the accurate reading, or the recipient does not receive nursing services during the time the study would be conducted, DMAS reimbursement will be limited to the time spent by the respiratory therapist, who must be present during the entire period of the study (8-10 hours), rental of the equipment for one day, and the scoring fee. In all cases, the CO_2 monitor must be equipped with a printer, and the DME provider must send the results of the study to the physician for interpretation.

Humidification Systems

DMAS will reimburse for an aerosol humidification system when the recipient's upper airway is bypassed. A vapor phase humidification system will be reimbursed when the recipient is on a ventilator. The components of the aerosol system are:

- Reusable dry nebulizer;
- Water trap;
- Compressor;

- Swivel adapter; and
- Corrugated tubing.

A disposable dry nebulizer will only be considered for reimbursement when it is expected that the need for the humidification system will be short-term; (it is expected that the tracheostomy will be closed).

A vapor phase humidification system will be considered for reimbursement for treatment of humidity deficit for a recipient with a tracheostomy only when there is justification for the necessity of this device versus an aerosol humidification system, and the aerosol humidification system is documented as contraindicated.

All humidification systems must be purchased except in those instances when humidification is expected to be required for less than nine months. Reimbursement will be a bundled rate for all the components of the system.

Oxygen

DMAS provides reimbursement to DME providers for medically necessary respiratory/oxygen equipment and supplies. Any respiratory/oxygen equipment and supplies must be physician-ordered via the CMN. The flow rate, frequency, and duration of use (an order for PRN use of oxygen must identify the circumstances under which oxygen is to be used) must be identified on the CMN as part of the physician's order. For portable systems, documentation must provide a description of the activities in which the recipient participates, on a regular basis, that require a portable system in the home, and the therapeutic purpose served by that portable system that cannot be met by a stationary system. Coverage of home oxygen and oxygen equipment will be considered reasonable and necessary only for recipients with significant hypoxemia who evidence the following laboratory results, health conditions and for whom the required medical documentation exists. (12 VAC 30-50-165)

Medical Documentation

While there is no substitute for oxygen therapy, it is appropriate that each recipient should receive optimum therapy before long-term home oxygen therapy is ordered. The physician must have examined the recipient recently (within 30 days of the start of therapy). If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The CMN must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate; and
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime). Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the recipient.

The physician must also specify the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator). If the type of system is not specified, the provider must provide services in the most cost-effective manner to carry out the physician's order and meet the needs of the recipient.

The physician must submit a new CMN whenever there is a revision to the oxygen requirements based on a change in condition and the subsequent need for oxygen therapy. In the absence of any revision, the CMN authorization is valid for a 12-month period for adults and six months for children. The physician may only certify the need for oxygen therapy if the recipient has been examined by a physician within the past 12 months.

Laboratory Evidence

The CMN must also include the results of a blood gas study ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO_2) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, will also be acceptable when ordered and conducted by a qualified provider or supplier of laboratory services and evaluated by the attending physician. The conditions under which the laboratory tests are performed must be specified in writing and submitted with the CMN (i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen, the amount, body position during testing, and any similar information necessary for interpreting the evidence).

In situations when the arterial blood gas and the oximetry studies are both used to determine the medical need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source for this determination.

A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. This prohibition does not extend to the results of an arterial blood gas test conducted by a hospital certified to do such tests. The preferred sources of laboratory evidence are existing physician and/or hospital records that reflect the recipient's medical condition. If more than one arterial blood gas test is performed during the recipient's hospital stay, the test result obtained closest to the hospital discharge date must be submitted. The attending physician's statement of recent hospital test results are acceptable in lieu of copies of the actual hospital records.

A DME provider may be the provider of pulse oximetry services, in accordance with the established DMAS pulse oximetry criteria, for a recipient with a progressive disease who may require oxygen at night. The overnight pulse oximetry study must be ordered by the physician, and the DME provider must send a copy of the pulse oximetry readings to the attending physician for interpretation. If the physician determines that oxygen therapy is medically indicated, the oximetry test results and the physician's order for oxygen therapy must be recorded on the CMN. DMAS will reimburse the DME provider for the oxygen therapy as ordered by the physician, and in accordance with the coverage criteria for oxygen therapy.

If the recipient is enrolled in MEDALLION, the ordering physician must be the

MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

A repeat arterial blood gas or oximetry study will normally be necessary only when evidence indicates that a recipient receiving oxygen has undergone a major change relevant to the home use of oxygen. For example, if there has been a significant increase in the amount of oxygen required (e.g., an increase to more than 4 liters per minute), a repeat blood gas or oximetry study may be necessary.

Health Conditions

Coverage is available for recipients with significant hypoxemia in a chronic and stable state if the following three conditions are met:

1. The physician has determined that the recipient has one of the following health conditions:

   - A severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuse interstitial lung disease of known or unknown etiology; cystic fibrosis, bronchiectasis; and symptoms of widespread pulmonary neoplasm; or

   - Hypoxia-related diagnoses or symptoms that might be expected to improve with oxygen therapy. Examples of these are pulmonary hypertension, recurring congestive heart failure (CHF) due to chronic cor pulmonale, erythrocytosis, impairment of cognitive processes, nocturnal restlessness, and morning headache.

2. The recipient meets the blood gas evidence requirements in Groups I-III:

   Group I: Coverage is provided for recipients with significant hypoxemia evidenced by at least one of the following:

   - An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air (an oxygen saturation at or below 94% is an acceptable level for children).

   - An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a recipient who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen. For children, the arterial oxygen saturation levels would be at or below 94%, taken during

sleep for a recipient who demonstrates an arterial oxygen saturation at or above 95%, while awake.

- An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during exercise for a recipient who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while at rest. In this case, supplemental oxygen is provided during exercise if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the recipient was breathing room air. For children, the arterial oxygen saturation levels would be at or below 94%, taken during exercise for a recipient who demonstrates an arterial oxygen saturation at or above 95%, while at rest.

Group II: Coverage is available for recipients whose PO_2 is 56-59 mm Hg or whose arterial blood oxygen saturation is 89%, if there is evidence of:

- Dependent edema suggesting cor pulmonale.
- "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF).
- Erythrocythemia with a hematocrit greater than 56%.

Group III: Coverage of home oxygen must be preauthorized by DMAS for recipients with arterial PO_2 levels at or above 60 mm Hg or whose arterial blood oxygen saturation is at or above 90% (or at or above 95% for children.) The physician must submit documentation, in addition to the CMN, which specifies why oxygen is medically necessary.

3. The recipient has appropriately tried other alternative treatment measures without demonstrable success or other forms of treatment have not been tried, but oxygen therapy is needed as part of the recipient's initial treatment.

Conditions for which oxygen therapy is not covered are:

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen is sometimes prescribed to relieve this condition, it is potentially harmful and may be psychologically contraindicated.
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the lungs.

- Treatment of headaches, including migraines.

- Treatment of other conditions in which oxygen therapy is determined to be experimental or investigational.

Any recipient who does not meet the criteria specified above may be allowed coverage only if the oxygen request is preauthorized and the physician is able to demonstrate that there is a medical risk that the recipient's condition could be complicated by his or her withdrawal from oxygen, and if the attending physician certifies that there is a continuing medical need for the recipient to receive oxygen. A miscellaneous oxygen code has been created for this purpose only and will require preauthorization.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

DMAS will not provide reimbursement for respiratory/oxygen equipment and supplies which do not meet medical necessity guidelines. Furthermore, DMAS will not provide reimbursement for oxygen and equipment which is not being used by the recipient, regardless of the medical necessity. The DME provider must monitor utilization and report to the physician when oxygen is not being used as prescribed. This notification must be in writing, and a follow-up must be submitted to DMAS which shows that either the recipient has resumed compliance with medical orders or continues to be non-compliant. If non-compliance continues, DMAS will notify the recipient of the effective date that coverage of the oxygen will cease.

DMAS reimburses for an oxygen set-up based upon the amount of oxygen used, prescribed liter flow rate, and whether humidification is used. The rate does not vary according to the type of oxygen system: concentrator, liquid system, or gaseous system. There are three reimbursement rates for oxygen set-ups, based upon the prescribed liter flow rate. The reimbursement is for daily rental of the system (with or without humidification) which includes:

- Oxygen set-up;
- Nasal cannulas;
- Extension tubings; and
- Bubble bottle for humidification, if needed.

A separate portable oxygen code can be used for reimbursement for portable oxygen, up to a maximum of 24 portables in a year without preauthorization. *(Except oxygen reimbursed under the miscellaneous oxygen code, HCPCS Z4238, where reimbursement includes the cost of the stationary system, the portable system, portable tanks, and all necessary supplies.)* Documentation must provide a description of the activities in which the recipient participates on a regular basis that require a portable system in the home, and the therapeutic purpose served by that portable system that cannot be met by a stationary system.

DMAS does not cover oxygen analyzers.

Pulse Oximetry (Continuous Pulse Oximeter Utilization)

Coverage for daily pulse oximetry may be available when ordered by a physician who can document that the recipient meets one of the following criteria:

- The recipient is dependent on both a ventilator and oxygen; or
- The recipient has a tracheostomy and is oxygen dependent; or
- The recipient has a tracheostomy and is unable, due to some factor such as age, developmental delay, cognitive status, or neuromuscular involvement, to summon assistance thereby placing the recipient at risk of obstruction of the tracheostomy; or
- The recipient requires supplemental oxygen and has unstable saturations. The desired saturation level will depend on the recipient's diagnosis and must be documented by the physician at the time continuous pulse oximetry is ordered. At the time of the next authorization period, the saturation levels will be reviewed for stability.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

A recipient who is ventilator-dependent with room air and who is stable does not qualify for daily pulse oximetry coverage.

Medical Documentation

The physician must document on the CMN that the recipient's condition meets <u>one</u> of the above criteria, that pulse oximetry readings are necessary on a daily basis in order for the recipient to remain in the home, that the recipient does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern), alternative treatments which have been attempted (e.g., periodic arterial blood gases), and why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO_2 trends over a specified period of time) would not meet the physician's need for monitoring. In addition, the physician must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 1/min.).

Laboratory Evidence

Documentation of the recipient's current SaO_2 must be submitted on the CMN and must show desaturation (SaO_2 less than 85% for adults and less than 94% for neonates).

Exceptions: DMAS will consider requests for daily pulse oximetry for recipients who do not meet the health condition criteria, but who require daily pulse oximetry due to complications presented (e.g., acute illness, weaning from oxygen use).

Reimbursement for pulse oximeters determined to be medically necessary in the home on a continuous basis will be reimbursed on a rental basis for a maximum of three months. The decision to rent the equipment must be based on the physician's attempt to wean the recipient from a tracheostomy or a ventilator, or when the recipient requires supplemental oxygen and has unstable saturations, but does not have a tracheotomy or ventilator, and the physician is unable to determine the length of time the recipient will require the continuous pulse oximetry. DMAS will purchase the pulse oximeter for any rental that exceeds two authorizations of three months each when the physician cannot definitely state how much longer the recipient will require the continuous pulse oximetry.

Reimbursement will be established for the oximeter with a recording device and a permanent probe (unless documented inability to attain an accurate reading exists which would justify use of disposable probes). There will be four rental rates: one for the use of the permanent probe, one for the use of disposable probes, and two additional rates for the inclusion of a battery pack, one with a disposable probe and one with a permanent probe, when determined medically necessary for the recipient who requires transport and is at risk of desaturation when transported. A copy of the pulse oximetry printout must be attached to the request for the rental preauthorization.

Pulse Oximetry (Periodic or Intermittent Pulse Oximeter Studies)

Coverage of pulse oximetry on a periodic or intermittent basis is available for any of the following conditions:

- Any recipient on a ventilator or on continuous oxygen when periodic pulse oximetry is ordered by the physician as a necessary component of monitoring appropriate oxygen saturation levels;
- Any recipient with a progressive disease that may require oxygen in the future (e.g., emphysema); or
- Any recipient for whom oxygen has been recently discontinued and for whom the oxygen saturation level is needed to indicate successful weaning.

The physician must order the frequency of pulse oximetry readings and the period of time over which the reading must be taken. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

The pulse oximetry reading must be submitted to the physician for assessment, and the physician must report back to the DME provider regarding any changes to be made based upon the reading taken.

Authorization of periodic pulse oximetry will only be given if there are persons in the home environment who are approved by the physician as trained and capable of recording accurate readings during the period of pulse oximetry. There is no DMAS reimbursement for the personnel who may be required to assure that the pulse oximetry readings are accurate. In the event that the physician is not satisfied that the family member can adequately monitor to assure that the reading is accurate, the periodic pulse oximetry may have to be performed in a sleep lab or hospital setting. Children who receive private duty nursing through the Technology-Assisted Waiver or EPSDT may have access to nursing services which can assure the accurate reading. All periodic pulse oximetry must be preauthorized by DMAS. The maximum allowable number of studies will be 12 in a 12-month period. (It is the physician's responsibility to assure that the persons who will be in the home during the periodic pulse oximetry are capable of assuring the accurate reading before authorization of the pulse oximetry is requested.)

Reimbursement to the DME provider for pulse oximetry studies includes a two-day rental of the monitor. To bill for pulse oximetry studies, a respiratory therapist must set up the equipment in the home. This rate will be all-inclusive; there will be no further reimbursement for printer, paper, probes or any other supplemental equipment. The DME provider will be responsible for sending a copy of the readings to the physician for interpretation.

Suction Machines

Suction machines are covered by DMAS for any recipient who has a tracheostomy or who cannot manage his or her own secretions. Suction machines will only be rented when the CMN indicates the expected length of use is three months or less. Suction machines must be purchased whenever the expected use exceeds three months. Purchase of the suction machine will include the cost of a portable back-up suction machine, one set of tubing, two collection jars, a battery, and a charger. Supplies can be purchased as necessary according to the limits in the "Medicaid DME and Supplies Listing" in Appendix B. Rental includes the cost of the rental of the machine and a portable backup, tubing, collection jars, a battery, and a charger.

Ventilators/CPAP/BiPAP

Both ventilators and non-continuous ventilators (i.e., CPAP/BiPAP) are covered items when ordered by a physician and preauthorized by DMAS. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The CMN from the physician must indicate the prognosis for weaning from the ventilator together with the expected length of use of the ventilator. The stability of the recipient on the ventilator at the time of discharge from the hospital, the need for continuous or periodic pulse oximetry, and the current or projected need for sleep studies must be addressed on the CMN.

Coverage of a CPAP/BiPAP will only be considered for reimbursement when documentation on the CMN includes the results of a sleep study, except for those recipients diagnosed with a neuromuscular disease. Those recipients with neuromuscular disease must have

demonstrated hypoventilation or hypoxemia documented with a pneumogram or overnight oximetry study. Preauthorization of the BiPAP is possible only if the CMN documents that use of the CPAP has been tried and is not a feasible alternative for the recipient. When BiPAP is ordered, the BiPAP "S" will be covered by DMAS unless the recipient has central apnea and requires the "ST" version. Condition of central apnea must be documented in the sleep study results submitted with the CMN. If the CPAP/BiPAP supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME listing in addition to the initial two-month rental period for these items.

Coverage of a non-continuous ventilator for an adult shall be for a two-month rental period. At the end of this period, the physician must determine whether continued use is indicated. In an adult, weight loss is usually the most significant factor to consider. If the recipient continues to need the ventilator support at the end of the two-month period, the equipment must be purchased as long as there is documentation that the recipient is compliant with the treatment and documentation clearly indicates recipient benefit (e.g., SaO_2, ABG's).

Coverage of a non-continuous ventilator for a child shall be based upon the expected length of use. Any time the CMN indicates that the ventilator/CPAP/BiPAP is to be used for a period which will exceed nine months, the equipment must be purchased. Purchase of the ventilator will include the cost of the ventilator, battery, charger, three sets of reusable circuits and valves, and an initial supply of filters. Purchase of the CPAP/BiPAP will include the cost of filters, tubing, headgear, and masks. DMAS will pre-authorize a service maintenance contract for all recipients for whom a ventilator/CPAP/BiPAP is purchased.

Service Maintenance for Ventilators

In accordance with the DMAS DME participation agreement, the DME provider agrees to provide authorized service maintenance for purchased ventilators for Medicaid-eligible recipients. The service maintenance requires preauthorization in order for the provider to be reimbursed. Following preauthorization, the provider may bill using the HCPCS codes in the DME Listing/Appendix B. All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will conduct monthly home visits to conduct a respiratory assessment and to check equipment.

- The provider agrees to perform routine maintenance of the ventilator in the home, replacing filters, cartridges or any other disposables associated with this routine maintenance. Routine maintenance supplies are not billed separately to DMAS by the DME provider; such items are included in the reimbursement for the service agreement.

- The provider agrees to send the ventilator to the manufacturer for routine servicing every 6,000 hours, or as recommended by the manufacturer. The cost for this routine servicing, including shipping and handling, are included in the

service maintenance agreement fee. The cost of parts which would constitute a repair may be billed separately, as a ventilator repair, under HCPCS code Z4454. Any ventilator repair which exceeds $500.00 must be preauthorized by DMAS. The cost of a back-up ventilator during the period of time that the purchased ventilator is at the manufacturer's for routine servicing is included in reimbursement for the service agreement.

- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the period of non-routine service or repair.

Service Maintenance for CPAP, BiPAP, and BiPAP S/T

In accordance with the DMAS participation agreement, the DME provider agrees to provide authorized service maintenance for purchased CPAP, BiPAP, and BiPAP S/T equipment for Medicaid-eligible recipients. The service maintenance requires preauthorization by DMAS in order for the provider to be reimbursed. Following preauthorization of service maintenance, the provider may bill using the HCPCS codes listed in the "Medicaid DME and Supplies Listing" in Appendix B. The following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will make regular home visits to conduct respiratory assessments and to check equipment. For CPAP and BiPAP, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing physician. After the first three months, visits must be made at a minimum of once every three months. For BiPAP S/T, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing physician. After the first three months, visits must be made at a minimum of once every other month.

- The provider agrees to abide by the recommended manufacturer maintenance schedule as defined in the "Manufacturer's Recipient Product Pamphlet" and "Service Manual."

- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the period of non-routine service or repair.

The cost of parts which would constitute a repair may be billed separately as a ventilator repair under HCPCS code Z4454. Preauthorization requests for CPAP, BiPAP, or BiPAP S/T repairs exceeding $500.00 must be submitted on a DMAS-351. Claims for service maintenance agreements must be submitted for the calendar month in which the service is rendered per the authorization.

Therapeutic Beds and Mattresses

Therapeutic beds are defined as devices that consist of specially equipped frames and turning mechanisms, specially equipped adaptive tables that rotate continuously, and specially designed support surfaces. The term "therapeutic beds" will be used to describe four categories of high-technology beds:

Air Fluidized beds use warm air under pressure to set small ceramic beads in motion which stimulate the movement of fluid. Beds in this category include, but are not limited to, Clinitron (Support Systems International), Skytron (Skytron), Fluidair (Kinetic Concepts), and SMI 5000 (SMI Recipient Care). This category of beds is contraindicated by clients who 1) have a history of electrolyte imbalance; 2) need the head of the bed elevated or need to frequently come to a sitting position (i.e., client's with pulmonary diseases); 3) have a large draining wound; or 4) have altered proprioception.

Air Loss devices are equipped with a mattress that contains a large volume of constantly moving air, water, mud, or sand. The mattress may be artificially heated. Beds in this category include, but are not limited to, Kinair (Kinetic Concepts), Flexicair (Support Systems International), Mediscus (The Mediscus Group), SMI 3000 (SMI Recipient Care), Biodyne (Kinetic Concepts), Therapulse (Kinetic Concepts), Restcue (Support Systems International), Pulmonair 40 (The Mediscus Group), Synergy Pulse (Cardio Systems), and Orthoderm (Health Products, Inc.). This group of beds should not be used by clients with altered proprioception or who are prone to infection as the warm air from the bed may increase the growth of bacteria.

Rotation or Turning beds have specially equipped frames and turning tables designed to turn in a forward or backward motion or that vibrate, fluctuate, or variate in continuous movements. Beds in this category include, but are not limited to, Turn and Tilt Paragon (SMI Recipient Care), Keane Mobility (The Mediscus Group), Rotorest (Kinetic Concepts), Circoelectric (Stryker), LIC Turnover Bed (Century Manufacturing Company), and Stryker Wedge Turning Frame (Stryker). This category of beds is contraindicated by clients with altered proprioception or with a history of orthostatic hypotension.

Mattresses with special support surfaces that are placed on top of a standard mattress or replace a standard mattress on a standard bed frame. Mattresses in this category include, but are not limited to, Fluid Flotation Mattress (filled with fluid and conform to the shape of the body); Non-Powered/Self-Adjusting, Alternating Air Mattress (have compartments in which air pressure is varied periodically throughout the mattress); and Foam Mattress (made of foam, in varying thickness, which alter the pressure imposed on bony prominences).

Special mattresses are contraindicated for clients 1) with altered proprioception; 2) with very sensitive skin; 3) who require additional padding on the bed, thereby negating the beneficial effect of the surface; and 4) with poor circulation.

The decision to use therapeutic beds must be based on reasonable and necessary requirements that include all of the following:

- All other alternative equipment and conservative treatment modalities must have been exhausted without success.

- The use of the bed will benefit the recipient to a degree not attainable by the use of other methods of care and treatment as measured by physician evaluation.

- If decubitus ulcer is the primary reason for the bed application, the recipient must have more than one decubitus ulcer, one of which is a Stage IV ulcer (i.e., has extensive ulceration compounded by penetration to the muscle and bone, usually with necrotic tissue and profuse drainage). (Exceptions: If the recipient has recently received a surgical flap to the ulcer and otherwise meets the therapeutic beds and mattresses criteria, DMAS may consider reimbursement for the bed application. If the recipient has skin breakdown, yet does not have more than one decubitus ulcer, one of which is a Stage IV ulcer, and otherwise meets the therapeutic beds and mattresses criteria, DMAS may consider reimbursement for a less expensive bed application, i.e., alternating pressure pad, gel type mattress, non-powered flotation mattress, etc.)

A physician must coordinate the home treatment regimen, which will include the use of other treatment modalities, where applicable, including, but not limited to, nursing care, appropriate nutrition, and the creation of a tissue-growth environment. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

- The treatment regimen must be evaluated, and its continued use recertified, at least every 62 days, by the physician. There must be written documentation describing all areas of skin breakdown. Documentation must be updated at least every 30 days. Documentation must include the total number of wounds, location, size (circumference and depth), drainage (amount, appearance, and odor), and the presence of tunneling and staging, as follows:

  - Stage I: Skin redness that is not relieved within 15 to 30 minutes of relief from pressure.
  - Stage II: Superficial skin excoriation or blister formation. Epidermal and/or dermal tissue involved.
  - Stage III: Full-thickness skin loss exposing subcutaneous tissue and producing serosanguineous drainage.
  - Stage IV: Full-thickness skin loss with invasion of fascia, muscle, and/or bone.

- The recipient must be bedridden or chair-bound due to immobility or a terminal/progressive disease process, or the recipient must have a medical condition where frequent manipulation of the body is contraindicated.

- In the absence of the proposed bed, the recipient would require care outside of the home, which would result in an increased financial expenditure.

- There must be documentation that a trained caregiver is willing and able to assist or supervise in carrying out the prescribed treatment regimen and to support the use and management of the therapeutic bed, including the problems that may occur. A trained caregiver must demonstrate knowledge of the use and intended benefits of the applicable therapeutic bed.

Home use of a therapeutic bed should NOT be considered if any of the following conditions are met:

- The bed is the only identifiable treatment modality being employed to treat the problem.

- The bedding system being used does not meet the positioning needs of the recipient.

- Use of the type of bed prescribed is medically contraindicated by the recipient's treatment plan as described above.

The use of therapeutic beds should be discontinued when:

- Documentation within the home health plan of treatment *or* physician progress notes demonstrates that the recipient's condition continues to worsen with the use of the bed; or

- A trained and willing caregiver is not available to assist with the prescribed treatment plan; or

- The required documentation does not demonstrate that the intended benefits of the bed are being accomplished; or

- Documentation indicates that the Stage IV decubitus ulcers being treated have improved to a Stage II (a decubitus ulcer that has cracked, blistered, or broken skin and shallow to full thickness injury). Once the decubitus reaches a stage II, DMAS would consider reimbursement of a lesser expensive mode of treatment. (i.e., alternating pressure pad, gel type mattress, etc.); or

- At any time, conditions for NOT considering use of a therapeutic bed exist.

The DME provider must certify that:

- The home electrical system is sufficient to meet the requirements of the proposed bed.

- The housing structure is adequate to support the weight of the bed or mattress as

well as will accommodate admission of the bed to the house.

Transcutaneous Electrical Nerve Stimulators (TENS)

Requests for transcutaneous electrical nerve stimulator units may be approved if all of the following criteria are met; these criteria are applicable to all types of transcutaneous electrical stimulators:

- Documentation verifies that other alternative equipment and conservative treatment modalities have been exhausted without success;
- The use of the TENS unit will benefit the recipient to a degree not attainable by the use of other methods of care and treatment;
- A physician must direct the home treatment regimen, which will include the use of treatment modalities including, but not limited to, nursing services and physical therapy. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP;
- The treatment regimen must be evaluated at least bi-monthly and can be determined effective after one month's use;
- The absence of this device would require that the recipient visit the physician or therapist for treatment or medications more often than with the device;
- There must be documentation that the recipient or the caregiver is able to manage the application of the device; and
- Rental of the TENS unit will be approved for the first two months, and purchase will be made after that period. Rental is only applicable to the initiation of new therapy. If the TENS device supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the Appendix B "Medicaid DME and Supplies Listing" in addition to the initial two-month rental period for these items.

The purchase of the TENS unit and supplies will be considered after the 60 day trial rental when all of the following occur:

- Documentation indicates that the recipient is compliant with treatment;
- Documentation describes how the TENS treatment modality is effective; and
- Use of the TENS unit is not contraindicated and/or not effective.

COVERAGE OF ORTHOTICS

Orthotic device services include devices that support or align extremities to prevent or correct deformities or improve functioning and services necessary to design the device, including measuring, fitting, and instructing the recipient in its use.

General Medicaid Population

Practitioners may bill for supplies and/or equipment, beyond those routinely included in the office visit, when used in the course of treatment in the practitioner's office. These supplies include ace bandage, sling, splint, rib belt, cervical collar, lumbosacral support, etc. The applicable CPT/HCPCS codes may be used when billing for a specific supply item used. See the "Durable Medical Equipment" section" in the *Physician Manual* for additional information.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

Items made for the recipient by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the DMAS approved outpatient rehabilitation visit. These items are billed as ancillary charges on the UB-92, HCFA-1450 Universal Claim Form.

Orthotics, including braces, splints, and supports, are not covered for the general adult Medicaid population under the DME program, with the exception of the Intensive Rehabilitation program described below.

Intensive Rehabilitation Program

Coverage for both adults and children is available for medically necessary orthotics when recommended as part of an approved intensive rehabilitation program (including CORF), and when all of the following criteria are satisfied via adequate and verifiable documentation. Documentation for orthotics must include:

- Ordered by the physician on the DMAS-352 (CMN), and if the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP;

- Directly and specifically related to an active, written, and physician-approved rehabilitation treatment or discharge plan;

- Based upon a physician's assessment of the recipient's rehabilitation potential, where the recipient's condition will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved

functional state of maintenance; and

- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

The orthotist participating as a DMAS DME provider coordinates completion of the DMAS-352 (CMN) with the prescribing physician, using the correct HCPCS "L" codes. Preauthorization is required and may be submitted either telephonically or on a DMAS-351 preauthorization request form. Documentation of the provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under the HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for time involved in fitting, measuring, and designing the orthotic, or for providing the recipient with instructions for proper use.

EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children's Specialty Services (CSS) to receive orthotics (effective December 1, 1997). All medically necessary orthotics are covered for children under the age of 21 years. The same program guidelines, as identified in the above paragraph, apply to this category.

COVERAGE OF PROSTHETICS

Prosthetic arms, legs, and their supportive devices are covered for all Medicaid recipients, and require preauthorization by the Medical Support Unit. Prosthetic providers must complete a prosthetic preauthorization request form and send to the Medical Support Unit for consideration. (See the "Coverage and Limitations" section in Chapter IV of the *Prosthetic Device Manual* for further instructions.)

MEDICAID WAIVER PROGRAMS

Technology-Assisted Waiver Program

Providers do not have to request preauthorization for equipment and supplies from the Health Care Coordinators at DMAS for recipients in the Technology-Assisted Waiver (effective March 1, 1999). All equipment and supplies for this population are handled by the DMAS contractor for preauthorization, WVMI. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP.

Providers must have a completed Certificate of Medical Necessity (CMN-352) for all equipment and supplies (effective March 1, 1999). Signed delivery tickets are not required as part of the preauthorization process. However, proof of delivery will be verified upon post payment review. If a recipient requires an item that needs preauthorization, the provider must call WVMI with the appropriate information. WVMI will approve, deny, or pend the request. Items that do not require preauthorization may be provided to the recipient in accordance with regular DME policy. Any item which requires preauthorization and

was previously authorized as part of a recipient's monthly rate, must be preauthorized by WVMI with a separate preauthorization number on March 1, 1999. Failure to obtain this preauthorization will result in the denial of payment.

AIDS Waiver Program

A recipient in the AIDS Waiver may receive any medically necessary DME available to the general Medicaid population. In addition, DMAS coverage of enteral nutrition under the AIDS Waiver is broader than that of the general Medicaid population as outlined in the "Enteral Nutrition Section."

Enteral Nutrition Coverage Criteria

Coverage of nutritional supplements for the general Medicaid population, which do not include a legend drug, are limited to when the supplement is the sole source form of nutrition and is necessary to treat a medical condition. Sole source is defined as the inability of the individual to handle (swallow or absorb) any other form of oral nutrition.

Coverage of nutritional supplements for individuals authorized through the Technology-Assisted and AIDS Waiver, or through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, is limited to when the supplement is at least the primary source form of nutrition and is necessary to treat a medical condition. Primary source is defined as being medically indicated for the treatment of the recipient's condition if the recipient is unable to tolerate nutrients. The recipient may either be unable to swallow any oral nutrition or the oral intake that can be tolerated is inadequate to maintain life.

Coverage is available for nutritional supplements regardless of whether the supplement is administered orally or through a nasogastric or gastrostomy tube. Coverage does not include the provision of "routine" infant formulae.

Eternal Nutrition Billing Instructions

Providers must use the appropriate HCPCS codes identified in the "Medicaid DME and Supplies Listing" when billing for nutritional supplements. If the supplement that is ordered by the physician is not listed, or the supplement does not clearly fall within one of the established nutritional supplement HCPCS classifications, the provider must contact the Provider HELPLINE to obtain the correct HCPCS code.

When billing for HCPCS codes B4154 or B4155, a copy of the DMAS-115 form and a copy of the manufacturer/supplier's invoice (identifying the cost) must be attached to the claim.

For all nutritional supplements, the HCFA-1500 claim form must identify in section 24A the appropriate from and through dates to indicate the length of time for which the supply was delivered. For example, if a nine-day supply was delivered, the from and through dates must be for a nine-day period (07/01/02-07/09/02). Additionally, the units (HCFA-1500 section 24G) must be calculated as follows: daily caloric intake, divided by 100, multiplied by the number of days supplied.

DME Covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program that provides screening and treatment for Medicaid recipients from birth to age 21. Some DME not otherwise available to Medicaid recipients may be available for this age group through the EPSDT program, if medically necessary.

When requesting preauthorization of equipment and supplies, the provider must determine whether the recipient meets the program requirements for DME or is under age 21. If reimbursement criteria are not met through the regular DME program policy, they may be met under EPSDT for recipients under age 21. For example, a child who needs a piece of equipment for transportation (e.g., a car seat), or a child who is able to ambulate in the home but requires a wheelchair for the school environment, may request coverage under EPSDT. If it is determined that the child will need a piece of equipment to function in the home environment, then the request may be covered under the DME program. Another common example is nutritional supplements which are not the sole source of nutrition. If a recipient, under the age of 21, is receiving some nourishment by mouth and some supplementation orally or by tube, the recipient does not qualify for coverage for the supplements under the DME program. The provider should then request the supplement through EPSDT, following the same process for preauthorization as the DME program.

DME Covered in Intensive Rehabilitation Settings

If the DME is for use only during the course of the rehabilitation program, these items are included in the per diem rate, and are entered on the rehabilitation hospital bill as ancillary services.

If the DME (e.g., wheelchair, hospital bed, recipient lift, etc.) is required to facilitate the recipient's discharge home or to an Adult Care Residence (not to an extended care facility) authorization/reimbursement would follow the DME criteria.

If the DME (e.g., customized wheelchair) is required to facilitate discharge to a nursing facility, the three options for reimbursement follow:

1) The cost of the equipment can be included on the rehabilitation hospital bill as an ancillary service.

2) The social worker from the nursing facility can assist the recipient in requesting preauthorization of the equipment via the "MAP-122 process." This is only an option if the recipient has a recipient co-pay toward the cost of long-term care. (For additional information, see the DMAS *Nursing Home Manual*.)

3) The cost of the equipment may be covered under the EPSDT program for children under the age of 21; preauthorization is required.

If the recipient is not eligible for any of these three options, outside resources would need to be explored (e.g., Department of Rehabilitation Services, OBRA fund for recipients with

specific disabilities with a date of onset prior to age 22, Consumer Service Fund, churches, etc.).

DME Covered in Nursing Facilities

Supplies and Equipment

Supplies and equipment that are medically necessary for the direct care and treatment of inpatients are covered nursing facility services and are included in the cost of the nursing facility services. These include, but are not limited to, wheelchairs, walkers, trapeze bars, eggcrate and other specialized mattresses, dressing or catheter trays, suture sets, special beds, IV infusion pumps, incontinent supplies, etc. Coverage of resident-specific, customized items must be made through the DMAS MAP-122 process (see the *Nursing Home Manual* for further instructions).

Certain medical supplies required to facilitate discharge are covered as allowable cost to the nursing facility. These supplies do not include items such as hospital beds and wheelchairs. Deductible and coinsurance amounts will be paid when these items are covered by Medicare.

If a nursing facility without a DMAS specialized care contract admits a resident requiring special equipment (e.g., ambulatory infusion pump, etc.) which is medically justified and prescribed by the physician, the nursing facility is responsible for obtaining the equipment. No additional Medicaid reimbursement will be provided to a DME provider or to the nursing facility.

Ventilators and Associated Supplies

DMAS requires preauthorization for all ventilators and associated supplies furnished to nursing facility residents who are not residing in a nursing facility with a DMAS specialized care contract. (12 VAC 30-50-165) Additional information on specialized care requirements for contracts can be obtained by calling the Supervisor of the Long-Term Care Section, at (804) 225-4222. Additional information on specialized care can be found in the Medicaid *Nursing Home Manual*, Chapter VI.

The nursing facility must supply ventilators and other special equipment or supplies needed by a recipient enrolled as a "specialized care recipient" and admitted to a nursing facility with a Medicaid contract for specialized services. The DME provider may not bill Medicaid for this equipment and supplies.

For those ventilator-dependent residents residing in a nursing facility without a DMAS specialized care contract, DMAS requires the nursing facility to obtain preauthorization before admitting the resident. DMAS will make direct reimbursement to DME providers for the following for nursing facility use for these residents:

- Ventilator rental
- Portable back-up suction machine
- Heated Cascade humidifier system
- Ventilator circuits
- Suction machine
- Suction catheter
- Sterile water
- Oxygen and oxygen equipment

- Tracheotomy tubes
- Tracheotomy care kits
- Tracheotomy dressing
- Manual resuscitator
- IV pole or other suitable support for circuits

The reimbursement to the DME provider includes the services and consultation of and teaching by a respiratory therapist to the nursing facility.

Requests for Medicaid payment for ventilators for recipients expected to be placed in nursing facilities without a DMAS specialized care contract must be sent to the Supervisor, Facility and Home Based Services Unit, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The written request for authorization must include all of the following:

- The recipient's Medicaid number;
- The present location of the recipient;
- The proposed nursing facility placement;
- The current medical status;
- The UAI, DMAS-96, and MI/MR Supplement;
- A written statement from the attending physician justifying the need and the type of equipment required. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP; and
- An itemized list of the equipment required, the rental cost of machine-associated supplies and services, and the name, address, and phone number of the respiratory equipment supplier.

RENTAL AND PURCHASE GUIDELINES

Equipment rental is indicated for short-term use when recipient's need or condition is expected to change, including when the recipient is expected to recover. When usage is anticipated to be long-term, and the recipient's need or condition is not expected to change, the items must be considered for purchase. Most items can be rented for a short time without preauthorization; an extension may be requested if the continued use is expected to continue short-term. If it is determined through utilization review activities that a rented item should have been purchased, DMAS will only provide reimbursement up to the established purchase price. (12 VAC 30-50-165) A description of the equipment and limitations for rental is found in the "Medicaid DME and Supplies Listing" in Appendix B.

The purchase prices listed in the "Medicaid DME and Supplies Listing" in Appendix B represents the amount that DMAS will pay for new equipment purchases. Unless otherwise approved by DMAS, documentation on the delivery ticket must reflect that the purchased

equipment is "new" upon the date of service billed. Any warranties associated with new equipment shall be effective with the date of service billed. Medicaid is the payer of last resort; therefore, the DME provider is responsible for exploring coverage available under the warranty prior to requesting coverage of repairs, etc., through DMAS.

DMAS will consider paying the full purchase price listed in the "Medicaid DME and Supplies Listing," in addition to the initial required two-month rental period, for communication devices, TENS Units, CPAPs, and BiPAPs, when this equipment is new upon delivery.

Medicaid reimbursement for rental items is a daily rate. DMAS will not provide rental reimbursement for days that the recipient is not receiving or using the services. DMAS will also not provide reimbursement for rental equipment that is damaged or abused by the recipient.

MANAGED CARE

Medallion

MEDALLION is a primary care case management program designed to link qualified recipients with a source for coordinated primary care and, in so doing establish a *medical home* for those recipients. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. This referral may be obtained in writing or orally and must be documented in the recipient's record. DME providers must follow the established DMAS criteria for providing medically necessary DME services for recipients with MEDALLION coverage. See the *Medallion Supplement* for more information.

HMOs

Some recipients are enrolled in HMOs through either the *Options* or MEDALLION II programs. See Chapter I for more detail about these programs. DME providers must contact the recipient's HMO directly for information regarding the contractual and reimbursement criteria for Medicaid covered services contracted to HMOs or optional services the HMO chooses to provide.

Insurance coverage must be verified before services are rendered. Failure to do so may result in denial of payment. To verify eligibility, call the HMO's enrollment verification system or the automatic response system (ARS) at 1-800-884-9730 (outside of Richmond) or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. If using the ARS system, HMO information, if applicable, follows Medicaid eligibility information. Providers who do not participate in the recipient's HMO must inform the recipient prior to the provision of service that the recipient will be responsible for payment.

Custom Preauthorized DME (*Options* and Medallion II)

DME providers who are billing DMAS for specialized equipment must have valid preauthorizations from DMAS dated prior to the date the recipient enters the HMO. This specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;
- Customized prone standers; and
- Customized positioning devices (HCPCS code Z4178).

For the items listed above, the DME provider may bill DMAS using the valid preauthorization begin date as the invoice date if DMAS preauthorization is received prior to the recipient's entering the HMO. The DME provider must maintain proof of delivery documentation. For DME provided to non-HMO recipients, the delivery date is used as the invoice date.

PAYMENT FOR SERVICES

General Information

The payment criteria established for medical supplies, equipment, and appliances are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible recipients can receive covered services at least to the extent that these services are available to the general population. Participation as a medical equipment and supply provider is limited to those who accept as payment in full the amounts paid by the Virginia Medicaid Program. Payments for services will not exceed the amounts indicated to be paid in accordance with the policy and methods described in Virginia Administrative Code, and payment will not be made in excess of the upper limits described in 42 CFR 447.304(a).

Cost Sharing

No Medicaid deductible or coinsurance amounts are imposed for any medical supplies, equipment, and appliances provided to Medicaid recipients. Medicaid will pay the Medicare deductible and coinsurance amounts up to Medicaid limits imposed on Medicaid recipients whose Medicare claims are processed initially by the Medicare carrier.

ORDERING FORMS

As a general rule, DMAS will no longer provide a supply of agency forms which can be copied using a standard copy machine or which can be downloaded from the DMAS web site (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

EXHIBITS

TABLE OF CONTENTS

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES

SECTION I **RECIPIENT DATA** **SERVICING PROVIDER** **CMN STATUS**

I.D. #		I.D. #	❑ INITIAL
Name		Name	❑ REVISED
D.O.B.		Contact Person	❑ RENEWED
Phone #	( )	Phone #	( )

SECTION II **RECIPIENT INFORMATION**

Answer all questions that are applicable to DME service being requested. If answer is yes, you must describe/attach additional information.

DESCRIPTION/ADDITIONAL INFORMATION: (Additional space on reverse)

Does patient:	YES	NO
1. have impaired mobility?	❑	❑
2. have impaired endurance?	❑	❑
3. have restricted activity?	❑	❑
4. have skin breakdown? (Describe site, size, depth and drainage)	❑	❑
5. have impaired respiration? (Identify most recent PO_2_____/Saturation level _____ for patients on oxygen)	❑	❑
6. require assistance with ADL's?	❑	❑
7. have impaired speech?	❑	❑
8. require nutritional supplements? (Identify complete diet order)	❑	❑

IS THE ITEM SUITABLE FOR USE IN HOME, AND DOES THE PATIENT/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE EQUIPMENT? YES___NO___

DATE PATIENT LAST EXAMINED BY PHYSICIAN _____

ICD9 Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months

SECTION III **(ADDITIONAL SPACE ON REVERSE)**

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered/ x1 Month	Quantity/Frequency of Use Justification/Comments

SECTION IV **PHYSICIAN CERTIFICATION** **(MUST BE SIGNED AND DATED BY PHYSICIAN)**

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PHYSICIAN'S NAME (print)	PHYSICIAN'S SIGNATURE	DATE	I.D.#	( ) PHONE #

DMAS-352, Revised 8/95

RECIPIENT NAME		VMAP #	
SERVICING PROVIDER NAME		PROVIDER ID#	

DESCRIPTION/ADDITIONAL INFORMATION

SECTION II (continued)

SECTION III (continued)

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered/ x1 Month	Quantity/Frequency of Use Justification/Comments

SECTION IV PHYSICIAN CERTIFICATION (MUST BE SIGNED AND DATED BY PHYSICIAN)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PHYSICIAN'S NAME (print) | PHYSICIAN'S SIGNATURE | DATE | I.D.# | ( ) PHONE #

Section I RECIPIENT DATA

- Complete 12-digit recipient identification number
- Complete recipient full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone # (include area code)

SERVICING PROVIDER

- Complete provider number (7-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

CMN STATUS

- Check appropriate box

Section II RECIPIENT INFORMATION

- Check **ALL** boxes that apply
- Identify functional limitations related to recipient and need for DME service
- If requesting oxygen, the results of PO_2/Saturation levels must be identified
- Date last examined by physician
- ICD9 Code (optional)
- Clinical diagnoses - narrative must be identified. Diagnosis must be related to the item being requested
- Check appropriate line for date of on-set

Section III

- Begin service date (month, day and year)
- Item ordered description: must be narrative description of item ordered (DME vendor may identify by HCPC Code)
- Length of Time Needed: length of time item will be needed for all durable equipment
- Quantity ordered: identify quantity ordered; for expendable supplies, designate supplies needed for 1 month; if items are required greater than 1 month, note time frame in the Length of Time Needed column
- Quantity/Frequency of Use, Justification/Comments: physician's order for frequency of use must be identified

Section IV PHYSICIAN CERTIFICATION

- Physician full name (print)
- *Must* be signed and fully dated by physician (**NOTE:** Attached physician prescription will ***not*** be accepted in lieu of physician signature/date on this form); IF ORDERS FOR **DME** SERVICE ARE WRITTEN ON BOTH SIDES OF FORM, PHYSICIAN ***MUST*** SIGN/DATE *BOTH* SIDES OF FORM
- Complete physician Medicaid provider number (optional)
- Telephone number (include area code)

SECTION I: TRANSACTION TYPE

____ Original
____ Change
____ Delete

Tracking Number: _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRE AUTHORIZATION REQUEST

Date Received

Mail request to: ATTN:_____ (See Section V)
DMAS PRACTITIONER
P. O. Box 27444
Richmond, Virginia 23261-7444

SECTION II: PROVIDER INFORMATION

Provider Name _____ Provider No: _____

Address:
Street _____ City _____ State _____ Zip _____

Contact Person: _____ Telephone: (_____) _____-_____

SECTION III: RECIPIENT INFORMATION

Recipient Name:

Recipient No.: _____ (Last) _____ (First) _____

Address:
Street _____ City _____ State _____ Zip _____

Telephone: (_____) _____-_____ Recipient's Birth Date: ___-___-____

Other Insurance: _____ Medicare Number: _____

SECTION IV: REFERRAL SOURCE INFORMATION

Provider Name _____ Provider No.: _____

Address:
Street _____ City _____ State _____ Zip _____

Contact Person: _____ Telephone: (_____) _____-_____

SECTION V: PROGRAM CATEGORY

Check ONE Appropriate Category (Mail to Attention of:)

CBC PROGRAM:
____ EPSDT (1)
____ Waiver (2)
____ Outpatient Psych (3)

HOME HEALTH:
____ Home Health (6)
____ DME (7)

MED. SUPPORT:
____ Medical Services (4)
____ Other Services (5)

REHAB UNIT:
____ Rehab (8)

SECTION VI: SERVICE CATEGORY

(Check One Appropriate Category)

____ DME (1)
____ Practitioners (2)
____ Pharmacy (3)
____ Inpt. Psych (4)
____ Outpt. Psych (5)
____ Other (6)
____ Home Hlth (7)
____ Rehab (8)
____ Hospital (9)

SECTION VII: REQUEST INFORMATION

	HCPCS / CPT Code / NDC / Revenue Code	HCPCS Modifier	Units Requested	Actual Cost per Unit	Total Dollar Request	Dates of Service From	Dates of Service Thru
(1)						__/__/__	__/__/__
(2						__/__/__	__/__/__
(3)						__/__/__	__/__/__
(4)						__/__/__	__/__/__
(5)						__/__/__	__/__/__
(6)						__/__/__	__/__/__

SECTION VIII: DMAS USE ONLY: Do Not Write in This Section

	ACTION STATUS	Approved Units	Approved Dollars/Units	Approved Dates From	Approved Dates Thru	Action Reason	Initials and Date
(1)	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__
(2	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__
(3)	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__
(4)	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__
(5)	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__
(6)	A ____ D ____ P ____			__/__/__	__/__/__	____	___ __/__/__

Provider Comments

Provider Signature _____ Date _____

Comments

DMAS 351 5/94

ATTACH DOCUMENTATION OF MEDICAL NECESSITY

INSTRUCTION FORM - PRE AUTHORIZATION REQUEST

SECTION I: Transaction Type

Check appropriate Transaction:
- Original - use for new requests
- Change - use for adjustment of original request
- Delete - use for void of original request

(Original tracking number must appear on all requests for changes and/or deletions)

SECTION II: Provider Information (Provider who will deliver and bill for requested service)

Provider Name:	Complete Address of Provider
Provider No.:	Complete Provider Number (7 DIGITS)
	Complete Address of Provider Identify locality that service is being provided from; (All correspondence will be sent to the address identified on your provider agreement)
Contact Person:	Identify the contact person for DMAS to call if the reviewer has questions
Telephone No.:	Identify the telephone number of the contact person (Including Area Code)

SECTION III: Recipient Information

Recipient No.:	Complete Medicaid Number (12 DIGITS) It is your responsibility to verify Recipient Medicaid eligibility before submitting request or providing items
Recipient:	Recipient's Full Name (Last & First Name)
Address:	Complete Address of Recipient (use current address of Medicaid Recipient; include box #, street address, city, state and zip code)
Telephone No.:	Complete Telephone Number of Recipient (Including area code)
Date of Birth:	Full Date of Birth (MONTH, DAY, YEAR)
Medicare No.:	Complete Medicare Number (10 DIGITS)
Other Insurance:	Identify any other insurance that the recipient has (include the name of the insurance carrier and the policy number if available)

SECTION IV: Referral Source Information (If the Provider making a referral for the requested services is not the same Provider who will deliver the service, this section should be completed)

Provider Name:	Full Name of Provider
Provider No.:	Complete Provider Number (7 DIGITS)
Address:	Complete Address of Provider (Use the current address of the referral source; include box number, street address, city, state and zip code)
Contact Person:	Identify the contact person for DMAS to call if the reviewer has questions
Telephone No.:	Identify the telephone number of the contact person (Including Area Code)

SECTION V: Program Category

Check the appropriate program from which recipient is eligible to receive requested service (Select only 1 program per request)

SECTION VI: Service Category

Check the appropriate category to which request refers (Select only 1 service category per request)

SECTION VII: Request Information

Procedure Code:	Procedure code (Revenue, HCPCS, or NDC Code) which identifies the specific service being requested, must be completed for request to be considered
	If a specific code is not established, please provide a complete narrative description of service being requested in the Provider Comment Section
Procedure Modifier:	Use appropriate Procedure Modifier; refer to Billing Chapter of the Provider Manual
Units Requested:	Identify Units requested using the established Billing Units; If authorization is needed because more than the established allowable is needed, Only list the amount in excess of the allowable
Actual Cost:	Must be completed when requesting service item that requires DMAS consideration for pricing (Request must include a Description, Manufacture name, Catalog number and copy of Purchase Invoice)
Total Dollar Requested:	Identify Total Dollars requested based on corresponding Procedure Codes and Units Requested
Dates of Service:	Identify Dates of Service for which the corresponding Procedure Codes and Units are Requested

Signature of Provider and Date of Request must appear in Section VII
ATTACH DOCUMENTATION OF MEDICAL NECESSITY; IF A HOME HEALTH PARTICIPANT, THE HOME HEALTH PLAN OF CARE MUST BE ATTACHED

SECTION VIII: DMAS USE ONLY - DO NOT WRITE IN THIS SECTION

MAIL TO: ATTENTION_____UNIT
DMAS PRACTITIONER
P. O. BOX 27444
RICHMOND, VIRGINIA 23261-7444

CASE EXAMPLE: MARY NEEDY

Mary Needy is a 42-year-old insulin dependent diabetic who has a right leg below the knee amputation. In June, 1997, she injured her left knee in a fall that resulted in a puncture wound, and she eventually developed osteomyelitis in the knee joint. After attempting to treat her on oral medication without success, her physician admitted her to the hospital, and on June 5, 1997, he sent her home from the hospital with a Hickman line in place. She was to receive two IV medications: Keflin 250mg q 4 hours and Vancomycin 250mg q 12 hours. On June 8, 1997, the recipient developed a rash and the Keflin was discontinued. On June 14, 1997, the recipient became dehydrated due to nausea and vomiting from a virus and was started on hydration therapy for two days to correct this problem. Hydration therapy was discontinued on 6/15/97 at 8 p.m. The recipient remained on Vancomycin until July 5, 1997, when laboratory values determined that the infection had resolved**.**

Billing by the DME provider: The recipient received DME Drug Therapy from 6/5/97 to 7/5/97 for a total of 31 days (only one service day rate for each of the days she received two antibiotics). The recipient received DME Hydration Therapy from 6/14/97 to 6/15/97 for a total of two days. Therefore, the DME provider may bill the full service day rate for DME Drug Therapy for 29 days (6/5/97 through 6/13/97 and 6/16/97 through 7/5/97) or $47.00/day. For the two days of multiple therapies (Drug and Hydration Therapy on June 14-June 15, 1997), the provider may bill the full DME Drug Therapy service day rate of $47.00/day and 50% of the DME Hydration Therapy service day rate or $15.00/day for a total of $62.00/day for each of the 2 days.

Billing by the pharmacy provider: The pharmacy provider may bill for a total of 31 days of Pharmacy Drug Therapy at $27.00/day and two days of Pharmacy Hydration Therapy at $8.00/day at 100% reimbursement for each day of service. The individual antibiotics/active ingredients are billed separately at the Medicaid allowable cost.

IV THERAPY IMPLEMENTATION FORM (DMAS-354)

SECTION I:

Recipient Name	
Recipient Medicaid Number	
Physician Name	
Type of Therapy	
Primary Diagnosis	
Secondary Diagnosis	
Recipient History (as relates to I.V. therapy)	
Therapy Start Date	
Anticipated Therapy End Date	
Route of Administration (type of line and device)	

SECTION II:

MEDICATION	DOSAGE	FREQUENCY	DURATION	START DATE	END DATE

SECTION III:
For TPN ONLY USUAL BODY WEIGHT----------
CURRENT BODY WEIGHT-------

Diagnosis related to GI dysfunction:
Dietary consultation: yes no
Enteral Nutrition attempted: yes no

SECTION IV:
Physician Signature:_____Date:_____

SECTION V:
Actual End Date of Therapy:_____

Physician Signature:_____**Date**:_____
*Note: A new form must be filled out for each new drug added and each new therapy initiated.

Instructions for completion of DMAS 354 IV Implementation Form

SECTION I: Recipient/Physician Information

Recipient Name: Recipient's Full Name (Last & First Name)

Medicaid Number: Complete Medicaid Number (12 digits)

Physician Name: Full Name of Physician

Type of Therapy:
*Hydration
*Pain Management
*Chemotherapy
*Drug Therapy
*TPN

*Each different therapy requires a separate I.V. Therapy Implementation Form.

Primary Diagnosis: Enter recipient's primary diagnosis.

Secondary Diagnosis: Enter recipient's secondary diagnosis if applicable.

Recipient History: Brief recipient history that led to implementation of I.V. Therapy.

Start Date: Start date of therapy

End Date: Anticipated end date of therapy

Type of Administration: Enter the route of I.V. administration and type of device used: peripheral line or CVP line and whether device is a PICC line, Groshong, Hickman, Port-A-Cath, etc.

SECTION II: Medication Information

Medication: Name of medication

NDC#: NDC number

Dosage: The dosage ordered

Frequency: Frequency of administration

Duration: Any special orders for duration, such as medication to run in over a certain number of hours

Start Date: The begin date

End Date: As each drug is discontinued, the end date is to be recorded under end date.

*There are 4 spaces to allow for an initial order of up to 4 medications. If new drugs are ordered during the course of a therapy, a new I.V. Therapy Implementation Form must be initiated as each new drug is ordered. A new CMN is not required unless a new therapy is added that was not placed on the original CMN. A new I.V. Therapy Implementation Form is required anytime a new therapy or new medication is ordered.

SECTION III: For TPN Only

Usual Body Weight: Enter weight.

Current Body Weight: Enter current body weight.

Diagnosis: Enter diagnosis related to GI dysfunction.

Enteral Nutrition: Enter if there has been a dietary consultation, and if enteral nutrition has been attempted.

SECTION IV:

Physician Signature: Physician must sign and date this form at the beginning of therapy. This must be done within 60 days of begin date of

therapy ordered. Subsequent I.V. Therapy Implementation Forms, as new medications added, must also be signed and dated within 60 days of begin date of the medication delivery.

SECTION V:

End Date: **Enter the date therapy actually ended (See Section I).**

Physician Signature: **Physician must sign and date at end of therapy.**

***NOTE: NEW FORM MUST BE FILLED OUT FOR EACH NEW DRUG ADDED AND EACH NEW THERAPY INITIATED.**

MATERNITY RISK SCREEN

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which _____ affects pregnancy, document below
7. _____ Previous fetal death

Substance Abuse	# days/week	# times/day
8. Alcohol	_____	_____
9. Cocaine/crack	_____	_____
10. Narcotics/heroin	_____	_____
11. Marijuana/hashish	_____	
12. Sedatives/ tranquilizers	_____	_____
13. Amphetamines/ diet pills	_____	
14. Inhalants/glue	_____	_____
15. Tobacco/cigarette	_____	_____
16. Other, please specify	_____	_____

B. SOCIAL

1. _____ Teenager 18 yrs or younger
2. _____ Non compliant with medical directions
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse/neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITION

1. _____ Pregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification, document condition below
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. _____ Care Coordination 2. _____ Nutritional Counseling 3. _____ Homemaker 4. _____ Parenting/ Childbirth Classes

5. _____ Glucose Monitor with nutrition counseling 6. _____ Smoking Cessation 7. _____ Substance Abuse Treatment

8. _____ No Care coordination _____

PROVIDERS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____